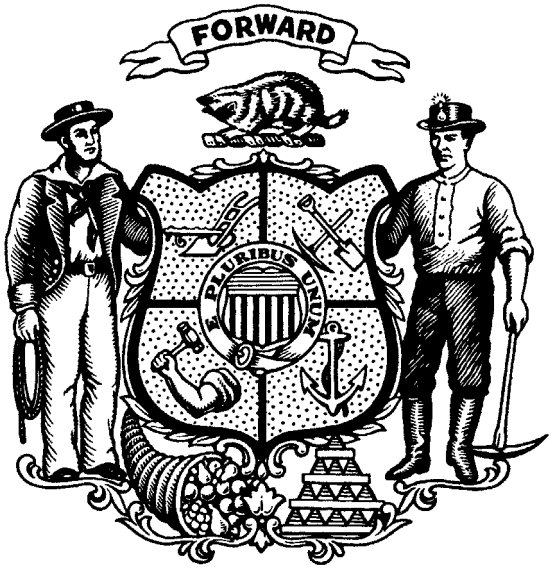


# CONTRACT

# BETWEEN

# WISCONSIN DEPARTMENT OF HEALTH AND FAMILY SERVICES
# DIVISION OF DISABILITY and ELDER SERVICES

# AND

# COMMUNITY CARE PARTNERSHIP, INC.

(*Fictitious Name)*

# 2004

**Wisconsin Department of Health and Family Services**

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**CONTRACT WITH**
**COMMUNITY CARE PARTNERSHIP, INC.**

**To Serve Medicaid-Only and Dual Eligible Participants**
**Under the**
**Wisconsin Partnership Program**
**Protocol**

## Preamble

The Wisconsin Department of Health and Family Services/Division of Disability and Elder Services (the Department), and Community Care Partnership, Inc. (CCP), a health care insurer with a certificate of authority or a waiver of licensure from the Office of the Commissioner of Insurance to do business in Wisconsin, and an organization which makes available to enrolled participants, in consideration of periodic fixed payments, comprehensive health and long-term care services provided by providers selected by the organization and who are employees or partners of the organization or who have entered into a referral or contractual arrangement with the organization, for the purpose of providing and paying for Medicaid contract services to recipients enrolled in CCP, under the State of Wisconsin Medicaid Plan approved by the Secretary of the United States Department of Health and Human Services (DHHS) pursuant to the provisions of the Social Security Act and for further specific purpose of promoting coordination and continuity of preventive health services and other medical care including emergency care, do herewith agree with the following terms of the contract.

This contract applies to Community Care Partnership, Inc., as the provider of integrated and comprehensive services to participants in the Wisconsin Partnership Program (Partnership).

The term of this contract shall be from January 1, 2004, through December 31, 2004.[1]

This contract describes desired outcomes, how it will be determined that the desired outcomes have been delivered, and standards of operations for contractors of the Wisconsin Partnership Program and the State of Wisconsin Department of Health and Family Services/Division of Disability and Elder Services, in relationship to Wisconsin Partnership Program contractors.

[1] See 42 CFR 422.504, "*Effective Date and Term of the Contract*."

ARTICLE I

I. DEFINITIONS

Terms that are not defined below shall take their meaning from the relevant portions of the Social Security Act (42 U.S. C. ss. 1396 et. Seq.), and HFS 101 through 108.

Action. The term "action" shall mean:

a. The denial or limited authorization of a requested service, including the type or level of service;
b. The reduction, suspension, or termination of a previously authorized service;
c. The denial, in whole or in part, of payment for a service;
d. The failure to provide services in a timely manner, as defined by the State; or
e. The failure of CCP to act within the timeframes provided in 42 CFR 438.408(b).

Adverse Action Date. The phrase "adverse action date" means the day during a given month when ten (10) days advance notice must be sent to a member before reducing or terminating benefits, so as to assure that the member has the notice in hand at least ten (10) days before the end of the month. Benefits are always reduced or terminated at the end of a month (unless the benefit is ending because the person died or the person has demanded immediate disenrollment). In a thirty-one (31) day month, adverse action is generally on the 18th; in a thirty (30) day month, it's on the 17th.

Appeal. The term "appeal" means a request for review of an action.

CCP. The term "CCP" means Community Care Partnership, Inc., a private, nonprofit non-stock section 501(c)(3) Wisconsin corporation that administers the Wisconsin Partnership Program.

CMS. The term "CMS" refers to the Federal Center for Medicare & Medicaid Services.

Community-Based Organization. The term "community-based organization" means a nonprofit agency providing community based health services such as nutritional support, health check screening, family planning, targeting such services to high risk populations.

Complaint. The term "complaint" means an expression of an enrollee's dissatisfaction about any matter other than an "action."

Cultural Competency. The term "cultural competency" means a set of congruent behaviors, attitudes, practices, and policies that enable providers to relate to the participant and to provide care with sensitivity, understanding, and respect for the member's culture. The related elements of cultural competence include understanding the dynamic of difference, institutionalizing cultural knowledge, valuing diversity, and adapting to and encouraging organizational diversity.

Department. The term "Department" means the Wisconsin Department of Health and Family Services.

Dialysis. The term "dialysis" refers to a process by which dissolved substances are removed from a patient's body by diffusion from one fluid compartment to another across a semi permeable membrane. The two types of dialysis that are currently in common use are hemodialysis and peritoneal dialysis.

Dual Coverage. The term "dual coverage" refers to services that are covered by both the Federal Medicare Program and the Wisconsin Medicaid Program.

Dual Eligible. The term "dual eligible" refers to an individual who meets the requirements to receive benefits from both the Federal Medicare Program and the Wisconsin Medicaid Program. "Dual eligibility" does not guarantee "dual coverage."

Eligibility. The term "eligibility" may refer to the Federal Medicare Program, the Wisconsin Fee-For-Service (FFS) Medicaid Program, and/or the Partnership Program. As it relates to the Federal Medicare Program and the Wisconsin Medicaid Program, the term "eligibility" is defined by Federal and State statutes and regulations. As it relates to participation in CCP's Partnership Program, the term "eligibility" refers to individuals who meet all of the following criteria:

a. Persons who are at least 18 years of age at the time of enrollment;
b. Mississippi County (*Fictitious County)* residency;
c. Eligibility for Medicaid or under provisions approved by CMS for the Partnership waiver;
d. Certification at a nursing home level of care; and
e. Any medical status.

Additional Requirements for Enrollment. CCP may not enroll in the Partnership Program:

a. Persons applying for Partnership enrollment who are dually-eligible for Medicaid and Medicare with a diagnosis of End Stage Renal Disease;
b. Persons who require Intensive Skilled Nursing (ISN) level of care.

Requirements for Enrollment of Dual-Eligibles. CCP can only enroll persons who are dually eligible for Medicaid and Medicare when those persons agree to receive their Medicare managed care benefits through CCP. In addition, CCP shall disenroll dual-eligible members who decide to receive Medicare managed care benefits from another provider.

Emergency Medical Condition. The term "Emergency Medical Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

a. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
b. Serious impairment to bodily functions.
c. Serious dysfunction of any bodily organ or part.

Emergency Dental Care. Emergency dental care is defined as an immediate service needed to relieve the patient from pain, an acute infection, swelling, trismus, fever, or trauma.

Emergency Services. The term "emergency services" means covered inpatient and outpatient services that are: (a) furnished by a provider that is qualified to furnish these services under this title; and (b) needed to evaluate or stabilize an emergency medical condition.

End Stage Renal Disease. The term "End Stage Renal Disease" is abbreviated "ESRD" and means that the stage of renal impairment that appears irreversible and permanent, and requires a regular course of dialysis or kidney transplantation to maintain life.

Enrollee. The term "enrollee" means a Medicaid recipient who has been certified as eligible to enroll under this contract, and whose name appears on Community Care Partnership's Enrollment Reports, which the Department will transmit to Community Care Partnership every month in accordance with an established notification schedule.

Enrollment Area. The term "enrollment area" means the geographic area in which recipients must reside in order to enroll in Community Care Partnership under this contract.

Enrollment Report. The term, "Enrollment Report" means the document that the Department transmits monthly to CCP in accordance with the notification schedule set forth in Addendum XIV.

Experimental Surgery and Procedures. The term "experimental" means services that the Department considers "not to be proven and effective" treatment for the conditions for which it is intended to be used, including transplant surgeries exclusive of cornea and kidney transplants.

Fraud. The term "fraud" means an intentional deception or misrepresentation made by a person or entity with the knowledge that the deception or misrepresentation could result in some unauthorized benefit to him/herself, itself or to some other person or entity. It includes any act that constitutes fraud under applicable Federal or State law.

Complaints. The term "Complaints" means an expression of dissatisfaction about any matter other than an action. The terms "Complaint" and "Grievance" are synonymous.

Home and Community-Based Waiver Services. This term means services covered under the either Wisconsin Community Options Program and the Wisconsin Community Integration Program.

Intensive Skilled Nursing Level of Care. The term Intensive Skilled Nursing (ISN) level of care means care requiring specialized nursing assessment skills and the performance of specific services and procedures that are complex because of the member's condition or the type or number of procedures that are necessary.

Long-Term Care Functional Screen (LTC-FS). The LTC-FS refers to the tool, approved by CMS and the Department, used to determine nursing home level of care.

Marketing Materials. "Marketing materials and other marketing activities" include the production and dissemination of any promotional material in all mediums, including member handbooks, brochures and leaflets, newspaper, magazine, radio, television, billboards, and Yellow Pages advertisements, and presentation materials used by marketing representatives that are mailed to, distributed to or aimed at Medicaid and Medicare recipients specifically, and any material that mentions Medicaid or Medicaid Assistance or Title XIX (Medical Assistance to low-income persons).

Medically Necessary. The term "Medically Necessary" means a service that is "required to prevent, identify or treat a recipient's illness, injury or disability." Medical necessity may only be determined by a physician or, where allowed under the Wisconsin Administrative Code, a nurse practitioner, licensed in the State of Wisconsin.

Medicaid. The term "Medicaid" means the Wisconsin Medical Assistance Program operated by the Wisconsin Department of Health and Family Services under the Social Security Act and under chapter 49, Wisconsin Statutes, and under related State and Federal rules and regulations. The term "Medicaid" will be used consistently in the Contract. "Medicaid" is also known as "MA," "Medical Assistance," "WMAP' and "T-19."

Member. The terms "member," "enrollee" and "participant" mean a person who is in CCP's Partnership program. (See Definition of Enrollee.)

Memorandum of Understanding. The term "Memorandum of Understanding" or "MOU" means an agreement detailing the actions of two parties under circumstances specified in the agreement.

Nursing Home Level of Care. The term "Nursing Home Level of Care" means a level of care provided in a nursing facility and reimbursable under the Medicaid program.

Protected Health Information. The term "Protected Health Information" or "PHI" has the same definition as set forth in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the regulations promulgated thereunder at 45 CFR Parts 160 through 164.

Partnership. The term "Partnership" means the Wisconsin Partnership Program (WPP) as further described in CMS's approval of the Partnership demonstration waiver of October 16, 1998.

Participant. The term "participant" has the same meaning as the term "enrollee," which is defined above.

Physical Disability. The term "Physical Disability" means "a physical condition, including an anatomical loss or musculoskeletal, neurological, respiratory or cardiovascular impairment, which results from injury, disease or congenital disorder and which significantly interferes with or significantly limits at least one major life activity of a person."

Post-eligibility Treatment of Income. This term means the contribution toward the cost of services by consumers required as a condition of eligibility. This term is commonly referred to as "cost share" in Wisconsin.

Post Stabilization Services. The term "Post Stabilization Services" means services related to an emergency medical condition that are either: (a) provided after an enrollee is stabilized in order to maintain the stabilized condition; or (b) provided to improve or resolve the enrollee's condition; coverage of Post Stabilization Services is defined under Article IV of this Contract.

Potential Member or Potential Enrollee. The term, means an MA recipient who is eligible to voluntarily enroll in WPP, but is not yet an enrollee.

Protocol. The term "Protocol" means the current protocol that serves as a legal instrument for the implementation of this Contract. Under this Contract, the Partnership Protocol is that one approved by CMS and the Department in October 1998 or as amended in collaboration with CCP and approved by CMS.

Public Institution. The term "public institution" has the same meaning as set forth in Wisconsin Administrative Code HFS 107.03(15).

Recipient. The term "recipient" means an "enrollee" or "member" in Community Care Partnership's programs. (See definition of "*Enrollee."*)

Risk. The term "risk" means the possibility of Community Care Partnership's monetary loss or gain resulting from service costs exceeding or being less than capitation payments made to it by the Department.

Risk Reserve. The term "risk reserve" means a segregated fund account that Community Care Partnership establishes to ensure continuity of care for its enrolled members, accountability to taxpayers, solvency protection against financially catastrophic cases, and effective program administration.

Subcontract. The term "subcontract" means any written agreement between Community Care Partnership and another party to fulfill the requirements of this contract. However, such term does not include insurance purchased by Community Care Partnership to limit its loss with respect to an individual enrollee.

Third Party Liability. The term "Third Party Liability" or "TPL" refers to the situations set forth at 42 USC. s.1396a(a)(26)(2001).

Transport by Common Carrier. Common carrier means any mode of transportation approved by a county or tribal agency, except an ambulance or a Specialized Medical Vehicle (SMV).

Urgent Care. The term "urgent care" is defined at Wisconsin Administrative Code Ins. 9.38.

## ARTICLE II

## DELEGATIONS OF AUTHORITY

A. Outcome

CCP is accountable for any and all functions and responsibilities that it delegates to any subcontractor including overseeing the quality of services provided by subcontractors.

1. Outcome is met when CCP:

    a. Acquires and maintains written agreements with subcontractors that:
        i. Specify the delegated activities and responsibilities; and,
        ii. Provide for revocation of the delegation or imposition of other sanctions if a subcontractor's performance is inadequate.
    b. Maintains oversight of subcontractors' quality of services within CCP's internal Quality Assurance/Quality Improvement (QA/QI) program;
    c. Demonstrates compliance through submission of the reports and/or updates to the Department per the Reporting Requirements in Addendum IV and;
    d. Delegation of Authority Review.

## ARTICLE III

## FUNCTIONS AND DUTIES OF COMMUNITY CARE PARTNERSHIP

*Contents:*



A. Outcome

CCP meets and maintains the basic requirements to perform the functions and duties under this contract.

The outcome is met when CCP retains the authority to operate, assures ethical standards, discloses potential conflicts of interest, and complies with other listed State and Federal standards.

B. Relationship with the Office of the Commissioner of Insurance

CCP is required to retain at all times during the period of this contract a valid Certificate of Authority issued by the State of Wisconsin office of the Commissioner of Insurance or obtain a waiver of licensure from the Office of the Commissioner of Insurance. Copies of all reports submitted to the Office of the Commissioner of Insurance will be submitted to the Department.

C. Assure Ethical Standards

CCP is required to promote the following ethical standards:

1. Management Subcontracts. The Department will review CCP's subcontracts for management operations and systems to assure that rates are reasonable.

a. Compensation for Services. Subcontracts for CCP management must clearly describe the services to be provided and the compensation to be paid.
b. Compensations. Any potential bonus, profit-sharing, or other compensation not directly related to costs of providing goods and services to CCP, shall be identified and clearly defined in terms of potential magnitude and expected magnitude during the CCP contract period.
c. Reasonableness. Any such bonus or profit-sharing shall be reasonably compared to services performed. CCP shall document reasonableness.
d. Specific Maximum Amount. A maximum dollar amount for such bonus or profit-sharing shall be specified for the contract period.

2. Subcontracts – Disclosure of Interest. CCP agrees to submit to the Department within thirty (30) days of contract signing, full and complete information as to the identity of each person or corporation with an ownership or controlling interest in CCP, or any subcontractor in which CCP has a five (5) percent or more ownership interest.

    a. Definition of "Ownership or Control Interest." A "person with an ownership or control interest" means a person or corporation that:
        i. Owns, directly or indirectly, five (5) percent or more of CCP's capital or stock or receives five (5) percent or more of its profits;
        ii. Has an interest in any mortgage, deed of trust, note, or other obligation secured in whole or in part by CCP or by its property or assets, and that interest is equal to or exceeds five (5) percent of the total property and assets of CCP; or
        iii. Is an officer or director of CCP (if it is organized as a corporation) or is a partner in CCP (if it is organized as a partnership).
    b. Calculation of five (5) Percent Ownership or Control. The percentage of direct ownership or control is the percentage interest in the capital, stock or profits. The percentage of indirect ownership or control is calculated by multiplying the percentages of ownership in each organization. Thus, if a person owns ten (10) percent of the stock in a corporation which owns eighty (80) percent of the stock of CCP, the person owns 8 percent of CCP. The percentage of ownership or control through an interest in a mortgage, deed or trust, note or other obligation is calculated by multiplying the percent of interest which a person owns in that obligation by the percent of CCP's assets used to secure the obligation. Thus, if a person owns ten (10) percent of a note secured by sixty (60) percent of CCP's assets, the person owns six (6) percent of CCP.
    c. Information to be Disclosed. The following information must be disclosed:
        i. The name and address of each person with an ownership or controlling interest of five (5) percent or more in CCP or in any subcontractor in which CCP has direct or indirect ownership of five (5) percent or more;
        ii. A statement as to whether any of the persons with ownership or control interest is related to any other of the persons with ownership or control interest as spouse, parent, child, or sibling; and
        iii. The name of any other organization in which the person also has ownership or control interest. This is required to the extent that CCP can obtain this information by requesting it in writing. CCP must keep copies of all of these requests and responses to them, make them available upon request, and advise the Department when there is not response to a request.
    d. Reported Information on Disclosure. This information may already have been reported on Form CMS-1513, "Disclosure of Ownership and Control Interest Statement." Form CMS-1513 is likely to have been completed in two different cases. First, if CCP is Federally qualified and has a Medicare contract, it is required to file Form CMS-1513 with CMS within one hundred twenty (120) days of CCP's fiscal year end. Secondly, if CCP is owned by or has

subcontracts with Medicaid providers which are reviewed by the State survey agency, these providers may have completed Form CMS-1513 as part of the survey process. If Form CMS-1513 has not been completed, CCP may supply the ownership and control information on a separate report or submit reports filed with the State's insurance or health regulators as long as these reports provide the necessary information for the prior twelve (12) month period. As directed by the CMS Regional Office (RO), this Department must provide documentation of this disclosure information as part of the prior approval process for contracts. This documentation must be submitted to the Department and the RO prior to each contract period. If CCP has not supplied the information that must be disclosed, a contract with CCP is not considered approvable for this period of time and no FFP is available for the period of time preceding the disclosure.

e. Prohibited Providers. A managed care entity may not knowingly have a person who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non procurement activities as a director, officer, partners, or person with beneficial ownership of more than five (5) percent of the entity's obligations under its contract with the State.

3. Disclosure Statement – Business Transactions. Party –In –Interest. CCP must disclose to the Department information on certain types of transactions that it has with a "party in interest" as defined in the Public Health Service Act.

a. Definition of a Party in Interest. As defined in Section 1318(b) of the Public Health Service Act, a party in interest is:

i. Any director, officer, partner, or employee responsible for management or administration of CCP; any person who is directly or indirectly the beneficial owner of more than five (5) percent of the equity of CCP; any person who is the beneficial owner of more than five (5) percent of CCP; or, in the case of CCP that is organized as a nonprofit corporation, an incorporator or member of such corporation under applicable State corporation law;

ii. Any organization in which a person described in subsection i is director, officer or partner; has directly or indirectly a beneficial interest of more than five (5) percent of the equity of CCP; or has a mortgage, deed of trust, note or other interest valuing more than five (5) percent of the assets of CCP;

iii. Any person directly or indirectly controlling, controlled by, or under common control with CCP; or

iv. Any spouse, child, or parent of an individual described in subsections 1, 2, or 3.

b. Types of Transactions That Must Be Disclosed. Business transactions, which, must be disclosed include:

i. Any sale, exchange, or lease of any property between CCP and a party in interest.

ii. Any lending of money or other extension of goods, services (including management services) or facilities between CCP and the party in interest; and

iii. Any furnishing for consideration of goods, services (including management services) or facilities between CCP and the party in interest. This does not include salaries paid to employees for services provided in the normal course of their employment.

c. The information, which, must be disclosed in the transactions listed in subsection B between CCP and a party in interest includes:

i. The name of the party in interest for each transaction;

ii. A description of each transaction and the quantity or units involved;

iii. The accrued dollar value of each transaction during the fiscal year and;

iv. Justification of the reasonableness of each transaction.

4. Extension Review. If this Contract is renewed or extended, CCP must disclose information on these business transactions which occurred during the prior contract period. If the Contract is an initial contract with Medicaid, but CCP has operated previously in the commercial or Medicare markets, information on business transactions for the entire year preceding the initial contract period must be disclosed. The business transactions which must be reported are not limited to transactions related to serving the Medicaid enrollment. All of these business transactions must be reported.

D. Program Integrity

1. General Requirements. CCP must have administrative and management arrangements or procedures, and a mandatory compliance plan, that are designed to guard against fraud and abuse. Fraud and abuse must be reported to the State in accordance with 42 CFR 455.17.

2. Specific Requirements. CCP's arrangements or procedures must include the following:

a. Written policies, procedures, and standards of conduct that articulates the organization's commitment to comply with all applicable Federal and State standards.
b. The designation of a compliance officer and compliance committee that are accountable to senior management.
c. Effective training and education for the compliance officer and the organization's employees.
d. Enforcement of standards through well-publicized disciplinary guidelines.
e. Provision for internal monitoring and auditing.
f. Provision for prompt response to detected offenses, and for development of corrective action initiatives relating to CCP's contract with the Department.

E. Other Requirement

1. CCP is required to meet all requirements of the Byrd Anti-Lobbying Amendment (31 USC 1352) which states that no appropriated funds may be expended by the recipient of a Federal contract, grant, loan, or cooperative agreement to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with any of the following covered Federal Actions: the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

2. CCP must safeguard against conflicts of interest in accordance with 1932(d)(3).

3. CCP must comply with the requirements of 45 CFR Part 74, Appendix A.

## ARTICLE IV

## SERVICE COVERAGE

*Contents:*



A. Outcome

Provide and/or purchase appropriate amount, duration and scope of medical and social services for Partnership participants.

The outcome is met when there is:

1. Approval of the Provider Network listed in the Provider Directory which meets all requirements specific to this article.

2. Approval of the "Semiannual Narrative Report" which meets all requirements specific to this article.

B. Service Delivery and Treatment – Team Model

CCP shall provide services through a comprehensive, interdisciplinary health and social services delivery system which integrates acute and long-term services pursuant to regulations and Partnership protocol.
*42 CFR 434.6(a)(4) Amount, duration and scope of services

C. General Statement of Coverage

1. Community Care Partnership shall be responsible for all services as defined by applicable State and Federal laws and legislation and related periodicals, including:

   *HFS 108.02 (4) and (7) Wisconsin Administrative Code: Provider Handbooks and Bulletins, Mailings and distribution
   *Wisconsin Statutes s. 49.46(2): Medical Assistance: Recipients of Social Security Aids and Benefits
   *Chapter HFS 107, Covered Services, Wisconsin Adm. Code;
   *Wisconsin Medicaid Program Provider Handbooks and Bulletins, as updated;

*42 CFR 441-Subpart E Abortions (Report Required)
*42 CFR 441.202 Abortions Prohibited
*42 CFR 441 Subpart F Sterilizations and Hysterectomies (Report Required)
*42 CFR 422.100-105, 112-114: Benefits and Beneficiary Protections Access to Service
*42 CFR 438.102(a)(2): Objecting to Provision of Service Based on Moral and Religious Grounds
*42 CFR 438.102(b)(1): Information to send to State if objecting
*42 CFR 438.114(e): Emergency and Post Stabilization Service Coverage and Payment: This applies to cites below through SSA1932(b)(2)
*42 CFR 438.114(b), (c)(1)(i), (c)(1)(ii)(A), (c)(1)(ii)(B)
*42 CFR 438.114(d)(1)(i), (d)(1)(ii)
*42 CFR 438.114(d)(2), (d)(3)
*42 CFR 438.206(b)(3) Second Opinions
*42 CFR 422.113(c), (c)(2)(i), (c)(2)(ii), (c)(2)(iii), (c)(2)(iv)
*42 CFR 422.113(c)(3)
*42 CFR 434.6(a)(4)
*SSA 1852(d)(2)
*SSA 1932(b)(2)
*42 CFR 438.206(b)(2) (CCP must provide female enrollees with direct to a women's health specialist within the network for covered care access necessary to provide women's routine and preventative health care services. This is in addition to the enrollee's designated source of primary care if that source is not a woman's health specialist.)
*42 CFR 438.210(a)(3)(i), (ii) and (iii): Appropriate Amount and Duration of Services Available
*42 CFR 438.206(b)(1) Delivery Network- Availability of Services
*42 CFR 438.207 (b) and (c) Documentation and Assurances of Adequate Capacity
*42 CFR 438.208(b)(2) Primary Care and coordination of health care services
*42 CFR 438.210(a)(3)(ii) Coverage of Services
*42 CFR 438.210 (a)(1) Coverage of Services
*42 CFR 438.210(b)(3): Denying a service authorization
*42 CFR 438.210(b)(1), (b)(2), (b)(3) Authorization of Services
*42 CFR 438.210(c) Notice of Adverse Action
*42 CFR 438.210(d)(1) Time Frame for Decision
*42 CFR 438.404(c)(3) Time Frames for Notice of Action: Standard Service Authorization Denial
*42 U.S.C. 1932(b)(3)(B) i and ii: Objecting to Provision of Service Based on Moral and Religious Grounds
*1915 (c) Waiver: Home and Community Based Waiver Services
*All exclusions of the demonstration and award letter of October 16, 1998;
*SSA 1852: Benefits and beneficiary protections
*COP Waiver Manual Chapters 1-9 and related appendices
*Partnership Protocol Manual

*Wis. Stats. s. 46.27(11) Medical Assistance Waiver Long-term Support and Community Options Program
*Current Member Handbook and disclosure Information
*42 CFR 438.6(m) Choice of Health Professional
*42 CFR 438.10(f)(4) Notice on Change of Information
*42 CFR 438.10(f) (5) Notice of Provider termination
*42 CFR 438.52(d), (c) Choice, Limitation on Changes of Primary Care Provider
*42 CFR 438.6(e) Services that may be covered

2. CCP is required to provide services that are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished.

3. CCP may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition.

4. CCP may place appropriate limits on a service on the basis of criteria such as medical necessity or for utilization control provided the services furnished can reasonably be expected to achieve their purpose.

5. CCP is not required to provide a counseling or referral service if CCP objects to the service on moral or religious grounds. If CCP elects not to provide, reimburse for, or provide coverage of, a counseling or referral service because of an objection on moral or religious grounds, it must furnish information about the services it does not cover as follows:

    a. To the Department;
    b. With CCP's application for a Medicaid contract;
    c. Whenever CCP adopts the policy during the term of the contract;
    d. It must be consistent with the provisions of 42 CFR 438.10;
    e. It must be provided to potential enrollees before and during enrollment;
    f. It must be provided to enrollees within ninety (90) days after adopting the policy with respect to any particular service.

6. Where and when CCP and its network of providers are unable to provide necessary medical services covered under the contract to a particular enrollee, CCP must adequately and in a timely manner cover these services out of network for the enrollee for as long as the CCP is unable to provide them. CCP must coordinate with out-of network providers with respect to payment.

7. CCP must make a good faith effort to give written notice of termination of a contracted provider, within fifteen (15) days after receipt or issuance of the termination notice, to each enrollee who received his or her primary care from, or was seen on a regular basis by, the terminated provider.

8. Post Eligibility Treatment of Income. Post eligibility treatment of income will apply to Partnership services.

9. Experimental Surgery. CCP will follow the guidelines for experimental surgery and procedures as follows:

    a. General Principle CCP does not pay for items that Wisconsin Medicaid determines to be experimental in nature. This may include, but not be limited to bone marrow transplants, liver, heart, heart-lung, lung and pancreas. Cornea and kidney transplants are not considered to be experimental in nature.
    b. Process for Transplants in WPP: CCP will be responsible for services per:
        i. DHFS Memo #4 January 18, 2000 and any subsequent changes
        ii. DHFS Memo #5 June 16, 2000
        iii. Member Handbook – Evidence of Coverage
        iv. HSS 107.035 Definition and identification of experimental services
        v. HSS 107.08(2) Services requiring prior authorization
        vi. Wisconsin Partnership Protocol - Manual Excluded Services
    c. CCP will pay for 'work up' and presurgery expenses.
    d. Exemption. CCP will continue to provide Medicaid-covered services until one of the following scenarios occurs:
        i. The hospital or transplant provider notifies CCP that the transplant has been performed. The participant will be permanently disenrolled for Medicaid-covered services effective the date the transplant surgery occurred. In the case of autologous bone marrow transplants, the person will be exempted from enrollment the date the bone marrow was extracted.
        ii. Sixty (60) calendar days have passed since the effective date of Medicare disenrollment. The participant will be disenrolled for Medicaid-covered services in accordance with standard involuntary disenrollment procedures in the Partnership Site Operations Protocol.
    e. Ineligibility for Partnership. Refer to Article VII Section C.1. regarding eligibility information surrounding transplants.

10. Dental Care Services. Be responsible for certain dental services as per HSS 107.07

11. County Transportation. Be responsible, when applicable, for arranging with County governments participant transportation by common carrier or private motor vehicle that CCP participants may require.

D. Coordination of 24-Hour Emergency Care

1. CCP coordinates all emergency contract services and post-stabilization services as defined in this contract twenty-four (24) hours each day, seven (7) days a week, either by CCP's own facilities or through arrangements approved by the Department with other providers. Services shall include but not be limited to 1 phone line to receive emergency calls. Individuals with authority to authorize treatment as appropriate must be accessible via this phone number.

2. CCP is responsible for coverage and payment of emergency services and post stabilization care services. CCP must cover and pay for emergency services regardless of whether the provider that furnishes the services has a contract with CCP in a manner consistent with Medicare and Medicaid regulations. CCP may not deny payment for treatment obtained when an enrollee had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in 42 CFR 438.114(a) of the definition of emergency medical condition or when CCP instructs the member to receive emergency care.

3. CCP in coordination with the attending emergency physician, or the provider actually treating the enrollee, is responsible for determining when the enrollee is sufficiently stabilized for transfer or discharge, and that determination is binding on CCP as identified in 42 CFR 438.114(b) as responsible for coverage and payment.

4. CCP is financially responsible for emergency services and post-stabilization services obtained within or outside CCP's network that are pre-approved by CCP.

5. CCP is financially responsible for post-stabilization care services obtained within or outside CCP's network that are not pre-approved, but administered to maintain, improve or resolve the enrollee's stabilized condition if:

    a. CCP does not respond to a request for pre-approval within 1 hour;
    b. CCP cannot be contacted; or
    c. CCP and the treating physician cannot reach an agreement concerning the enrollee's care and a plan physician is not available for consultation. In this situation, CCP must give the treating physician the opportunity to consult with the CCP care team or medical director. The treating physician may continue with care of the patient until the CCP care team or medical director is reached or one of the criteria in paragraph 7. a. through d., below, is met.

6. Payment for post-stabilization service must be made in a manner consistent with Medicare and Medicaid regulations.

7. CCP must limit charges to enrollees for post-stabilization care services to an amount no greater than what the organization would charge the enrollee if he or she had obtained the services through CCP. CCP's financial responsibility for post-stabilization care services it has not pre-approved ends when:

    a. The enrollee's primary care physician assumes responsibility for the enrollee's care;
    b. The enrollee's primary care physician assumes responsibility for the enrollee's care through transfer;
    c. CCP and the treating physician reach an agreement concerning the enrollee's care;
    d. Or the enrollee is discharged.

E. Urgent Care

CCP members must have access to urgent care services during regular business hours of Urgent Care facility. The Emergency Room (ER) is used when Urgent Care is closed.

F. Provision of Family Planning Services

When applicable, CCP members must have access to family planning services, whether the provider is or is not part of the network. If the participant chooses an out of plan provider, CCP will reimburse the out of plan provider of those family planning services according to the Wisconsin Medical Assistance Fee for Service rule and rates. All such information and medical records relating to family planning shall be kept confidential.

G. Services – Unavailable and Excluded

CCP shall inform applicant, on or before an individual enrolls under this Contract, in a written and prominent manner, of any benefits to which the participant may be entitled to under this Contract but which are not available through CCP. The Partnership Protocol and Member Handbook contain lists of excluded services.

H. Provision of Services

1. Authorizations: CCP must establish a prior authorization policy that identifies the services that require authorization as well as the process for requesting and granting prior authorizations. This is to include the following time frames.

    a. Authorization Time Frames. Authorization decisions must be made within the following time frames and, in all cases, as expeditiously as the enrollee's condition requires:
        i. Within fourteen (14) days of the receipt of the request; or,
        ii. Within seventy-two (72) hours if the physician indicates or CCP determines that following the ordinary time frame could jeopardize the enrollee's health or ability to regain maximum function.

2. CCP may be permitted one extension of up to fourteen (14) days if the enrollee requests it or if CCP justifies the need for more information.

3. Any decision to deny a healthcare related service authorization request or to authorize a healthcare related service in amount, duration, or scope that is less than requested, must be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease. Any decision to deny a non-healthcare service must be made by a person with appropriate expertise related to the requested service.

4. CCP must notify the requesting provider of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice to the provider need not be in writing.

5. Changes in Covered Services. Changes to Medicaid or Medicare covered services mandated by Federal or State law subsequent to the signing of this Contract will not affect the contract services for the term of this Contract, unless: (1) agreed to by mutual consent, or (2) the change is necessary to continue receiving Federal funds, or due to actions of a court of law:

    a. Capitation Adjustment. The Department may incorporate any change in covered services mandated by Federal or State law into the contract effective the date the law goes into effect, if the law adjusts the capitation rate accordingly.
    b. Changes by Mutual Agreement. The Department will give CCP thirty (30) days notice of any such change that reflects service increases, and CCP may elect to accept or reject the service increases for the remainder of that Contract year. The Department will give CCP sixty (60) days notice of any such change that reflects service decreases, with the right of CCP to dispute the amount of the decrease within that sixty (60) day period. CCP has the right to accept or reject service decreases for the remainder of the Contract year.
    c. Date of Change Implementation. The date of implementation of the change in coverage will coincide with the effective date of the increased or decreased funding. This section does not limit the Department's ability to modify this Contract due to changes in the State Budget.

6. Changing Primary Providers. CCP shall inform members that they have the right to change primary providers two times in any calendar year and to change primary providers more often than that for just cause. If CCP is not able to accommodate an enrollee's choice of primary provider, the enrollee may voluntarily disenroll from the program.

## ARTICLE V

## PROVIDER NETWORK

*Contents:*



A. Outcome

CCP will assure that there is an appropriate range of services and access to preventive and primary care services.

The outcome is met when there is approval of:

1. CCP's provider network by the Department and CMS.

B. Assuring Approval and Oversight

1. Department's Authority. The Department and CMS have the authority to review, approve, approve with modification, or deny:

a. Subcontracts under this Contract;
b. Review and approve CCP's provider network on an annual basis.
*42 CFR 434.6(a)(5) Department Oversight

2. General Requirements. The Department and CMS require:

a. Written Documents. CCP must assure that all subcontracts shall be in writing, shall comply with the provisions of this Contract and shall include any general requirements of Article V, Provider Network, and assure that all subcontracts shall not terminate legal liability of CCP under this contract. CCP may

subcontract for any function covered by this Contract, subject to the requirements of this Article V.

*42 CFR 438.206(b)(1) Availability of Services – Delivery Network – Written Agreements

*42 CFR 438.224 Confidentiality

*45 CFR parts 160 &164 HIPAA

*42 CFR 438.208(b)(4) Coordination and Continuity of Care

*42 CFR 434.6(b) and (c)

b. Notices for Discontinuing, Terminating Services/Providers shall be in accordance with 42 CFR 438.210 section c and S438.404.

C. Assuring Services of Qualified Providers

1. Certified Providers – Medicaid. For all Medicaid covered services, CCP will use certified Medicaid providers as per:

*WI Administrative Code 105 "Provider Certification"

*42 CFR 422.204 "Provider Selection and Credentialing"

*42 CFR 438.214(a) Provider Selection

*42 CFR 438.206(b)(6) Delivery Network

*42 CFR 438.610(a) and (b) Prohibited Affiliations with Individuals Debarred by Federal Agencies

*1932(d)(4) Physician Identifier

2. Exceptions: Exceptions may include emergency medical services and non-clinical services or as otherwise requested by CCP and approved by the Department.

3. For all non-Medicaid State plan services, CCP will select qualified providers.

4. Provider Selection (Non-Discrimination) CCP will follow applicable Federal and State laws relating to nondiscrimination as per:

*42 CFR 422.204 Provider Selection and Credentialing

*42 CFR 438.12(a)(1) Provider Discrimination

*42 CFR 438.214(c) Provider Discrimination

*Americans with Disabilities Act of 1990, 42USC Section 1210

*42 CFR 438.214(d) Provider Selection

5. Practice Guidelines: CCP will adopt practice guidelines that meet the following requirements:

a. Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;

b. Consider the needs of the enrollees;

c. Are adopted in consultation with contracting health care professionals; and

d. Are reviewed and updated periodically as appropriate.

*42 CFR 438.236(b) Practice Guidelines
*HFS 107.035 Definition and Identification of Experimental Services

6. CCP must disseminate the guidelines to all affected providers and, upon request, to enrollees and potential enrollees.

*42 CFR 438.236(d) Dissemination of Guidelines

7. Health Information System: CCP must ensure that data received from providers is accurate and complete by:

a. Verifying the accuracy and timeliness of reported data;
b. Screening the data for completeness, logic, and consistency; and
c. Collecting service information in standardized formats to the extent feasible and appropriate.
*42 CFR 438.242(b)(2) Health Information Systems

8. CCP will use only CLIA certified laboratories as specified by 42 CFR Part 493D.

9. Access Standards. CCP will assure that access to covered services will be in accordance with current CMS "Guidelines for Access Standards" attached as Addendum III to this contract.

* 42 CFR 438.206(c)(1)(i), (c)(1)(iv), (c)(1)(v), (c)(1)(vi) Furnishing of Services- Timely Access

D. Assuring the Use of Standard Language

The Department's subcontract review will assure that CCP has the following standard language in subcontracts (except for specific provisions that are inapplicable in a specific CCP management subcontract).

*42 CFR 438.230(a), (b)(1), (b)(2), (b)(3), (b)(4) Subcontractual Relationships and Delegation General Rule and Specific conditions

1. General Conditions. <Name of subcontractor>(hereafter identified as subcontractor) agrees to abide by all applicable provisions of CCP's contract with the Department, hereafter referred to as CCP contract. Subcontractor compliance with CCP contract specifically includes but is not limited to the following requirements.

2. Required Provisions. The Subcontract agrees:

a. Certification. To use only MA-certified providers in accordance with Article V, C, Assuring Services of Qualified Providers.
b. Liabilities. The terms of this subcontract shall not terminate legal liability of CCP under the contract with the Department.

c. QA/QI. To participate and contribute data to CCP's QA programs as required.
d. Emergency Services. To provide timely emergency and urgent care. Where applicable, subcontractor agrees to follow required hospital/emergency room procedures for urgent and emergency care cases.
e. Reporting. To submit utilization data in the format specified by CCP in order to meet the Department specifications.
f. Records – Retention. To comply with all record retention requirements.
g. Records – Access. To provide representatives of CCP, as well as duly authorized agents or representatives of the Department and CMS, access to its premises and its contract and/or medical records.
h. Records – Confidentiality. To preserve the full confidentiality of medical records and protect from unauthorized disclosure all information, records, and data collected under the Contract. Access to this information shall be limited to persons who, or agencies which, require the information in order to perform their duties related to this Contract, including CMS and such others as required by the Department.
i. Records-Maintenance and Transfer. To maintain and transfer medical records as stipulated by CCP contract and to make medical records available to members and their authorized representatives within a period not to exceed thirty (30) days if the records are maintained on site and sixty (60) days if maintained off site. 45 CFR 164.524(3)(b)(2)
j. Records-Complaints: To forward to CCP medical records pursuant to appeals within fifteen (15) working days of the request or, immediately, if the appeal is expedited. If the subcontractor does not meet the fifteen (15) day requirement, the subcontractor must explain reason(s) for the delay and indicate when the subcontractor will deliver the required medical records.
k. Complaints and Appeals. To inform providers (hospitals, clinics, individual physicians), in CCP's network about the complaint/appeal procedures and rights of CCP member.
l. Access. Not to impose requirements on recipients that are inconsistent with the provision of medically necessary and covered Medicaid and Medicare benefits (e.g. TPL recovery procedures that delay or prevent care) and that create barriers to access to care.
m. Member Protection. To ensure that all contractual or other written arrangements with providers prohibit CCP providers from holding any beneficiary member liable for payment of any fees that are the legal obligation of CCP as per:

*42 CFR 422.502(q)(l)(i) Contract Provisions between the M+C and CMS

*1903(m)(L)(A)(ii) of the SSA – Contract Provisions, Beneficiary Financial Protection

n. Non-Discrimination. To comply with all non-discrimination requirements in CCP Contract in accordance with the Americans with Disabilities P.L. 101-336 and Americans with Disabilities Act 1990, 42 USC Section 1210.
o. Referral. To clearly specify referral approval requirements to its providers and in any sub-subcontracts.

p. Billing. Not to bill a Medicaid and Medicare member for medically necessary services covered under CCP contract. This provision shall continue to be in effect even if CCP becomes insolvent. However, if an enrollee agrees in writing to pay for a non-MA or non-Medicare covered service, then CCP, the CCP provider, or the CCP subcontractor can bill the member. Subcontractor also agrees not to bill enrollees for any missed appointments while members are enrolled in WPP.

q. Marketing. To abide by CCP's marketing/informing requirements. Subcontractor will forward to CCP for prior approval all flyers, brochures, letters, and pamphlets the subcontractor intends to distribute to its WPP enrollees concerning its managed care affiliation(s), changes in affiliation, or relates directly to the Partnership population. Subcontractor will not distribute any "marketing" or recipient informing materials without the consent of the CCP and the Department.

r. Non-Payment – Appeals. To abide by the terms of CCP contract regarding appeals for non-payment of services.

E. Insolvency Protection

Under current law, s.1903(m)(l)(A)(ii) of the Social Security Act, members enrolled in CCP are not liable for the debts of CCP or its subcontractors in case of CCP's insolvency.

*1932(b)(6) Protect Against Liability
*42 CFR 438.106(a) All 438.106 are Liability for Payment
*42 CFR 438.106(b)(1), (b)(2)
*42 CFR 438.106(c)
*42 CFR 438.6(1) Contract Requirements
*42 CFR 438.230 Sub-contractual Relationships and Delegation
*42 CFR 438.204(a) Elements of State Quality Strategies
*42 CFR 438.116(a) Solvency Standards

F. Protection of Enrollee-Provider Communications

The Department prohibits interference with physician advice to member. CCP must not prohibit or otherwise restrict health care professionals from advising beneficiaries about their health status, medical care, or treatment regardless of whether benefits for such or treatment are provided under the contract.

*1932(b)(3)(D) Alternative Treatment
*42 CFR 438.102(a)(i), (a)(ii), (a)(iii), (a)(iv) Provider Enrollee Communications- General Rules

G. Assuring Access to Documents and Records

Access to Medicaid Documents and Records. CCP agrees to maintain for 6 years all books, records, subcontracts, documents and other materials relating to all provisions, reimbursements

and activities related to this contract. CCP shall ensure the Department's, CMS, and their duly authorized representatives' right to inspect, evaluate, and audit these materials through 6 years from the final date of this contract period or completion of audit, whichever is later.

*42 CFR 438.6(g) Inspection and Audit of Financial Records
*45 CFR 74.53 Uniform Administrative Requirements…Retention Requirements

H. Assuring Cultural Competency as required by the Partnership Protocol

*42 CFR 438.206(c)(2) Cultural Considerations

I. Assuring Fair Payment Practices

1. The Department's subcontract review will assure that CCP has conducted and conducts fair payment practices.

2. Payment to Subcontractors.

a. CCP Claim Retrieval System. Maintain a claim retrieval system that, upon request, can identify date of receipt, action taken on all provider claims (i.e., paid, denied, other), and when action was taken.
b. Thirty (30) Day Payment Requirement. Pay at least ninety (90) percent of adjudicated (clean) claims from subcontractors for covered medically necessary services within thirty (30) days of receipt of clean claim, ninety-nine (99) percent within ninety (90) days, and one hundred (100) percent within one hundred eighty (180) days except to the extent subcontractors have agreed to later payment. CCP agrees not to delay payment to subcontractors pending subcontractor collection of third party liability (TPL) unless CCP has an agreement with their subcontractor to collect TPL.

*42 CFR 447.46 Timely Claims Payment by MCOs
*42 CFR 447.45 (d)(2), (d)(3), (d)(5), (d)(6) Timely Processing of Claims

c. Inappropriate Payment Denials. If CCP inappropriately fails to provide or deny payments for services, may be subject to suspension of new enrollments, withholding, in full or in part, of capitation payments, contract termination, or refusal to contract in a future time period. This clause applies not only to cases where the Department has ordered payment after appeal, but also to cases where no appeal has been made (i.e., the Department is knowledgeable about the documented abuse from other sources).
d. Payments for Court-Ordered Services. Pay for covered services provided by a non-CCP provider to any participant pursuant to a court order (for treatment), effective with the receipt of a written request for referral from the non-CCP provider, and extending until CCP issues a written denial of referral. This requirement does not apply if CCP issues a written denial of referral within seven (7) days of receiving the request for referral.

J. Physician Incentive Plans

1. The Protocol on "Partnership Physician Arrangement – Physician Incentive Plan" details these requirements as per:

    a. 42 CFR 422.208, 417.479 PIP: Requirements and Limitations
    b. Stark Laws I & II
    c. SSA 1903(m)(2)(A)(viii) & SSA1903(m)(4): Disclosure of ownership and Report Transactions
    *42 CFR 438.6(h) Physician Incentive Plans
    *42 CFR 438.210(e) State Requirements
    *1903(m)(2)(A)(x) Prohibition
    *42 CFR 422.210 Disclosure of PIP
    *42 CFR 438.6(h) PIP Requirements
    *42 CFR 434.70(a)(3) Conditions for FFP (Federal Financial Participation)

2. Requirements. CCP may operate a Physician Incentive Plan only if no specific payment of any kind is made directly or indirectly under the plan to a physician or physician group as an inducement to reduce or limit covered medically necessary services furnished to individuals enrolled in CCP. Indirect payments include offerings of monetary value (such as stock options or waivers of debt) measured in the present or future.

K. Assuring Fair Process to Providers' Appeals

1. CCP will conduct fair payment practices in accordance with:

    a. SSA 1903: Contract Provisions
    b. 42 CFR Section 422.108-110

2. Emergency Services – Liability. Unless a contract or Memorandum of Understanding (MOU) specifies otherwise, CCP is liable to the extent that Medicaid FFS would have been liable for the emergency situation. The Department reserves the right to resolve disputes between CCP, hospitals and urgent care centers regarding emergency situations based on FFS criteria.

3. Appeals must be submitted to the Department within sixty (60) days of the date of written notification of CCP's final decision resulting from a request for reconsideration.

4. The Department has forty-five (45) days from the date of receipt of all written comments to respond to these appeals. CCP will pay provider(s) within forty-five (45) days of receipt of the Department's final determination.

L. Ineligible Association

Upon obtaining information or receiving information from the Department or from another verifiable source, CCP shall exclude from participation all organizations which could be included in any of the following categories:

1. Entities Which Could Be Excluded Under Section 1128(b)(8) of the Social Security Act.

2. Entities Which Have a Direct or Indirect Substantial Contractual Relationship with an Individual or Entity Listed which could be excluded under Section 1128(b)(8) of the Social Security Act.

3. Entities Which Employ, Contract With, or Contract Through Any Individual or Entity That is Excluded From Participation in Medicaid under Section 1128 or 1128A, for the Provision (Directly or Indirectly) of Health Care, Utilization Review, Medical Social Work or Administrative Services.

M. Payments

1. Billing Members – Allowed Practices. If a member agrees in advance in writing to pay for a non-Medicaid and/or non-Medicaid home and community-based waiver services or a non-Medicare covered service, then CCP, its provider, or its subcontractor can bill the member. A standard release form does not relieve CCP and its providers and subcontractors from the prohibition against billing a Medicaid member in the absence of a knowing assumption of liability for a non-Medicaid covered service.

2. Billing Members – Disallowed Practices. CCP and its providers and subcontractors will not bill a member for medically necessary services covered under the contract and provided during the member's period of CCP enrollment, except as provided for in the post-eligibility treatment of income. Any provider who knowingly and willfully bills a Partnership member for a Medicaid covered service may be guilty of a felony and upon conviction shall be fined, imprisoned, or both, as defined in Section 1128B.(d)(1)[42 U.S.C. 1320-7b] of the Social Security Act. This provision shall continue to be in effect even if CCP becomes insolvent.

    *42 CFR 438.106(b) and (c) Protect Against Liability- State Non-Payment
    *42 CFR 438.6(1) Contract Requirements
    *42 CFR 438.230 Subcontractual Relationships and Delegation
    *42 CFR 438.204(a) Elements of State Quality Strategies

3. Payments. Be responsible for payment of all contract services provided to all recipients listed as ADDs or CONTINUEs on either the Initial or Final Enrollment Reports generated for the month of coverage. Additionally, CCP agrees to provide or authorize provision of, services to all Medicaid enrollees with valid Medicaid ID

identification cards indicating CCP enrollment without regard to disputes about enrollment status and without regard to any other identification requirements. Any discrepancies between the cards and the reports will be reported to the Department for resolution. CCP shall continue to provide and authorize provision of all contract services until the discrepancy is resolved. This includes recipients who were PENDING on the Initial Report and held a valid Medicaid identification card indicating CCP enrollment, but did not appear as an ADD or CONTINUE on the Final Report.

4. Payments to Federally Qualified Health Centers (FQHCs). If CCP contracts with a facility or program, which has been certified as an FQHC, for the provision of services to its enrollees CCP must increase the FQHC's payment in direct proportion to the annual increase CCP receives from the Department for physicians. In other words, if CCP receives a ten (10)_ percent increase from the Department for physicians' services, the contracted rates paid to the FQHC either through capitation or FFS, must be increased by at least ten (10) percent over those that were in effect on the date this contract is signed.

N. Reporting

If CCP contracts with an FQHC, it must report to the Department within forty-five (45) days of the end of each quarter (for example, January 1 – March 31 is due May 15) the total amount paid to each FQHC, per month as reported on the 1099 forms prepared by CCP for each FQHC. FQHC payments include direct payments to a medical provider who is employed by the FQHC.

## ARTICLE VI

## MARKETING AND MEMBER MATERIALS

*Contents:*



A. Outcome

Marketing information is appropriate and accurate, and does not mislead, confuse or defraud members or consumers.

The outcome is met when all marketing materials are approved by CMS and the Department.

B. Department's Approval of Marketing Materials

CCP shall submit to Department for prior written approval all marketing materials, including all information regarding the provider network, prepared for Medicaid-only or Medicaid/Medicare recipients. All marketing materials and any changes to marketing materials must be approved by the Department and CMS prior to distribution. All marketing materials shall be distributed to CCP's entire service area.

1. Review Consideration. The Department will review marketing plans and materials in a manner which does not unduly restrict or inhibit CCP's marketing strategies.

2. Timeline for Department's Approval. The Department will review marketing plans and materials within forty-five (45) days. Marketing materials must also be approved by the Department and CMS prior to distribution.

3. Necessary Information. CCP must ensure that a potential member or a member receives accurate oral and written information sufficient to make informed choices.

4. Integrity of Informing. CCP's marketing materials shall be accurate and not mislead, confuse or defraud recipients or otherwise misrepresent CCP, its marketing representatives, the Department, or CMS. Statements that would be considered inaccurate, false, or misleading include, but are not limited to any assertion or statement (whether written or oral) that:

a. The recipient must enroll in CCP in order to obtain benefits or in order to not lose benefits; or
b. CCP is endorsed by CMS, the Federal or State government, or other similar entity.

C. Prohibited Practices

The Department prohibits the following marketing practices:

1. Tie-ins with other insurance products;

2. Cold calls, either door-to-door or telephone;

3. Offer of material or financial gain to Medicaid or Medicare recipients as an inducement to enroll; and

4. Activities that could mislead, confuse or defraud consumers.

D. Member Handbook

1. General Requirement. Provide to CCP members or their legal representatives, within one week of initial enrollment notification, annually thereafter and whenever the enrollee requests, a member handbook which is appropriate for, and easily understood by, its target population and has been reviewed and approved using the process established by CCP's internal advisory body, the Department and CMS. Before a significant change may take effect, CCP must provide members with written notice at least thirty (30) days prior to the intended change. The Department will have final authority to determine what is a significant change.

2. Required Information. The handbook at a minimum will include information about:

a. Being a Member of the Partnership Program. This information shall include the nature of Partnership membership as compared to FFS and requirements related to lock-in and prior authorization for services;
b. Policies on the Use of Emergency and Urgent Care Facilities;
c. Phone Number:
    i. The toll free phone number that can be used for assistance in obtaining emergency care or for prior authorization for urgent care;
    ii. A toll free number where enrollees and potential enrollees can acquire information about the requirements and benefits of the program;
d. Location of facilities;
e. Hours of Service;
f. Information on Contract Services Offered by CCP;
g. Members' Rights and Responsibilities;
h. Voluntary Enrollment or "Lock-In";
i. Complaint Procedures;

j. Appeal Procedures;
k. Expedited Review;
l. Prior Authorization Policy;
m. Second Medical Opinion;
n. Billing Members;
o. Advance Directives;
p. Member Liability for unauthorized services; and
q. Disenrollment.

E. Handbook Updates and Non-English Versions

1. Handbook Updates. CCP must provide periodic updates to the handbook, as needed, explaining changes in the above policies. Such changes must be approved by the Department prior to distribution.

2. Non-English Versions. Enrollee handbooks (or substitute enrollee information approved by the Department which explains CCP services and how to use CCP) shall be made available in at least the following languages: Spanish, Russian, Lao, and Hmong if CCP has members who are conversant only in those languages.

As an alternative to making available the entire member handbook in Spanish, Russian, Lao, and Hmong, CCP may:

a. Insert a note in the Interpreter Services Section of the member handbook. The note shall be written in each of the above languages and will direct the member to a customer service number for assistance in understanding the handbook and in receiving services, or
b. Include in the handbook a note that directs the members who are not conversant in English to the appropriate resources within CCP for obtaining a copy of the handbook with the appropriate language.

3. Standard Language. Standard language for complaint and appeal rights as well as for emergency services and urgent care may be provided by the Department and shall appear in all handbooks.

F. Reading Comprehension and Cultural Sensitivity

Materials for marketing and for health-promotion or wellness information produced by CCP must be appropriate for its target population and reflect sensitivity to the diverse cultures served. An internal advisory body composed of consumers, experts on readability and health related subjects will establish a process to review and approve the health educational materials produced by CCP. Also, if CCP uses material produced by other entities, CCP must review these materials for appropriateness to its target population and for sensitivity to the diverse cultures served. Finally, CCP must make all reasonable efforts to locate and use culturally appropriate health-related materials.

G. Right to Publish

The Department agrees to allow CCP to write and have such writing published provided CCP receives prior written approval from the Department before publishing writings on subjects associated with the work under this contract. CCP agrees to protect the privacy of individual CCP participants, as required under "General Requirements."

H. Failure to Abide

Any contractor who fails to abide by marketing requirements may be subject to any and all sanctions available under Article XVII, Remedies for Violation. In determining any sanctions, the Department will take into consideration any past unfair marketing practices, the nature of the current problem, and the specific implications on the health and well-being of the members. In the event that CCP's affiliated provider fails to abide by these requirements, the Department will evaluate whether CCP should have had knowledge of the marketing issue and the ability to adequately monitor ongoing future marketing activities of the subcontractor(s).

## ARTICLE VII

## ENROLLMENTS AND DISENROLLMENT SYSTEMS

*Contents:*



A. Outcome

CCP's enrollment and disenrollment practices are both legal and fair.

The outcome is met when CCP:

1. Follows written policies and procedures regarding enrollments and disenrollments which comply with applicable Federal and State laws and legislation;

2. Does not discriminate against individuals eligible to enroll on the basis of race, color or national origin and does not use any policy or practice that has the effect of discriminating on the basis of race, color or national origin; and, does not discriminate in enrollment and disenrollment activities between individuals on the basis of medical history, current medical condition (except mental illness), required health care services, income, pay status, claims experience, or any other factor not applied equally to all.

B. Applicable Laws and Legislation

CCP shall comply (to the extent compliance is required in light of the demonstration terms and conditions of October 16, 1998) with all applicable Federal and State laws and legislation relating to the outcome, including:

*42 CFR 422.110 Discrimination Against Beneficiaries Prohibited
*42 CFR 438.56 Disenrollment: Requirements and limitations
*42 C.F.R 438.6 Contract Requirements
*Wis. Stats. 146.81 Health care records; definitions
*42 CFR 422.50 Eligibility to Elect an M+C Plan
*42 CFR 422.54 Continuation of Enrollment
*42 CFR 422.56 Limitations on Enrollment in an M+C MSA Plan
*42 CFR 422.57 Limited Enrollment Under M+C RFB Plans
*42 CFR 422.60 Election Process

* 42 CFR 422.62 - Election of Coverage Under an M+C Plan
* 42 CFR 422.64 - Information About the M+C Program.
* 42 CFR 422.66 - Coordination of Enrollment and Disenrollment Through M+C Organizations
*42 CFR 422.68 - Effective Dates of Coverage and Change of Coverage
*42 CFR 422.74 - Disenrollment by the M+C Organization
*42 CFR 422.80 - Approval of Marketing Materials and Election Forms
*42 CFR 431, Subpart F - Safeguarding Information on Applicants and Recipients
*Division of Health Care Financing Policy Memo #3 November 5, 1999 entitled
*Integration of Medicaid and Medicare Benefits in PACE and in Partnership Managed Care Programs"
*Wis. Administrative Code HFS 104.01(6) – Coverage While Out of State

C. General Conditions Regarding Enrollment

1. CCP shall provide voluntary and continuous open enrollment for anyone who:

   a. Is eligible for Medicaid or under provisions approved by CMS for the Partnership waiver to be determined prior to enrollment and annually thereafter;
   b. Is functionally eligible as determined via the Long-Term Care Functional Screen prior to enrollment and annually thereafter;
   c. Is living in the designated service area;
   d. Has not had one or more transplant surgeries considered experimental by the Wisconsin Medicaid Program; and
   e. Is within the target group served by the contractor.

2. Enrollment of new members will take place in the following order:

   a. The date that all eligibility criteria were met;
   b. The date that the referral was received if the date of the referral was the same for two or more members who met the eligibility criteria on the same date; and
   c. The time that the referral was received if the date of the referral was the same for two or more members who met the eligibility criteria on the same date.

3. CCP has no limits on how many potential members eligible for Partnership may be enrolled in a given period of time. The Department, however, has established target member months of enrollment for the current Wisconsin biennial budget. The Department will inform CCP of the target member enrollment months as they are established and any adjustments to the targets on a semi-annual basis. CCP must monitor its utilization of member months and notify the Department immediately when CCP's actual enrollment experience varies significantly (3% or more) from the target.

4. The Department will regard people who have been in nursing facilities with funding provided by Medicaid (no Medicare) for no less than thirty (30) consecutive days as nursing home, long-term care recipients. CCP will make information on relocations available to the Department upon request.

5. Non-Enrollment

CCP may request a non-enrollment for any of the following reasons:

a. Protocol #1. The individual has a demonstrated history of physical aggression which places others and/or self at risk as demonstrated by clinical/medical records, family information, etc., AND, documented previous attempts at treatment or plan intervention have been unsuccessful, resulting in physical risk to the individual or others.

b. Protocol #2. The potential member has a history of willful non-compliance with an essential treatment plan which has resulted in significant physical risk to the individual. This protocol is applicable if:

   i. The willful non-compliance and the physical risk have been actively occurring in the 6 months prior to the non-enrollment request;
   ii. The willful non-compliance and the physical risk is evidenced by medical records; and
   iii. The physical risk to the individual continues.

c. Protocol #3. The potential member and/or potential member's family/guardian express the desire for the potential member to remain at home (or, if the potential member is currently in a nursing home or an alternative setting such as a CBRF, to return home) but the team, along with the potential member, the potential member's primary care physician and CCP's medical director, cannot develop a care plan which complies with WPP practice guidelines and the standards of practice for medicine and nursing in Wisconsin.

d. Protocol #4. The potential member has a less-than-six-month life expectancy.

e. Protocol #5. The potential member and/or potential member's guardian or durable power of attorney for health care refuse an essential component of the treatment plan.

f. Protocol #6. The potential member, at the time of referral, is living in substitute care (substitute care includes but is not limited to Nursing Home, Adult Family Home, or CBRF) with no desire to change residence or cannot with natural supports and the program return to their own or their family home.

g. Protocol #7. The potential member has a primary diagnosis which is excluded in the capitation rate. This includes, but is not limited to, people with mental retardation (a full scale IQ of 70 or less as ascertained by recent testing); people with major mental illnesses who are currently a risk to themselves or others as documented by the treating psychiatrist; and people with traumatic head injuries where cognitive and behavioral symptoms are evident.

h. Protocol #8. The potential member's physician does not meet Partnership criteria or the potential member's physician refuses to participate in the Partnership model and the potential member refuses to change physician.

6. Non-Enrollment Procedures

a. The Department will review CCP's request for non-enrollment and either approve or disapprove it in writing within fifteen (15) days.
b. If the Department disapproves the request for non-enrollment, CCP shall contact the person and offer enrollment.
c. Notification to Applicant: If the Department upholds CCP's denial, CCP must send written notification to the applicant with the following information:
    i. A statement that the enrollment is denied;
    ii. A written notification to applicant explaining the reason for denial;
    iii. A statement advising the applicant about the rights of the applicant to appeal the denial; and that the applicant may appeal to CCP, the Department, and/or the Division of Hearings and Appeals.
d. CCP shall not counsel or otherwise discourage enrollment of a potential enrollee with a confirmed diagnosis of AIDS, as indicated by an ICD-9-CM diagnosis code or who is HIV-Positive if that person is on antiretroviral drug treatment approved by the Federal Drug Administration.

D. Voluntary Disenrollment

CCP shall not counsel or otherwise encourage voluntary disenrollment of an enrollee with a confirmed diagnosis of AIDS, as indicated by an ICD-9-CM diagnosis code or who is HIV-Positive if that person is on antiretroviral drug treatment approved by the Federal Drug Administration.

Members may voluntarily disenroll without cause at any time.

E. Involuntary Disenrollment

1. Involuntary Disenrollment from Partnership. CCP may not request disenrollment because of a change in the enrollee's health status, or because of the enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs (except as specified in items a. through d. below). The Department has approved the following special "Protocols for Disenrollment" from Partnership:

a. The member has a demonstrated history of ongoing, willful non-compliance with an essential treatment plan that has resulted in significant physical risk to the individual as demonstrated by clinical records, and that risk continues.
b. The cognitively impaired member's informal support system fails to protect the member from abuse and/or neglect in the home setting, AND, there is

significant risk to the person, AND, the family or guardian refuses an alternate living setting.

c. The program no longer has a contract with the member's physician, AND, the member refuses to change physicians.

d. The member has committed acts of physical or verbal abuse that pose a threat to CCP staff, subcontractors or other members of CCP. This includes but may not be limited to verbally threatening behavior or an exhibition of harassing behavior.

2. Department Approval for Involuntary Disenrollment.

Involuntary disenrollment from Partnership requires the Department's approval. A proposed involuntary disenrollment shall be subject to timely review and prior authorization by the Department, pursuant to Subsection 3, Involuntary Disenrollment Procedure, below. CCP can request involuntary disenrollment for any of the following reasons:

a. Absence. When the member is out of the service area for more than thirty (30) consecutive days, unless CCP agrees to a longer absence due to extenuating circumstances (see 42 CFR 460.164(a)(3)).

b. Protocol Provisions. When a member's case meets one of the protocols for disenrollment, pursuant to Section 1, Involuntary Disenrollment from Partnership, above.

c. Contract termination or loss of either HMO Licensure or exemption from HMO Licensure.

3. Involuntary Disenrollment Procedure.

a. Disenrollment Request. CCP shall submit to the Department a written request to process all involuntary disenrollments. With each request, CCP shall submit to the Department evidence attesting to the above situations.

b. Department's Approval. The Department will notify CCP about its decision to approve or disapprove the involuntary disenrollment request within fifteen (15) days from the date the Department has received all information needed for a decision.

Upon Department approval of the disenrollment request, CCP must, within three (3) business days, forward copies of a completed Disenrollment Request form to the County Economic Support Worker and to the Medicare enrollment agency (for dual eligibles).

c. Notification to the Member. When the Department approves CCP's request, CCP must send written notification to the member that includes:

i. A statement that CCP intends to disenroll the member;

ii. The reason(s) for the intended disenrollment; and

iii. A statement about the member's right to challenge the decision by asking for reconsideration from the Department to disenroll and how

to appeal such a decision. (See Partnership protocol on "Complaint and Appeals.")

4. The Department will make all involuntary disenrollment decisions based upon criteria and procedures set forth in this contract and will be effective as described in Addendum I.

5. Disenrollment Appeal. If the member files a written appeal of the disenrollment within ten (10) days of the decision to disenroll (see Article IX, L.), disenrollment shall be delayed until the appeal is resolved.

F. Loss of Waiver Eligibility

1. A member can lose Partnership waiver eligibility for the reasons stated below (a.-d.). The effective disenrollment dates for loss of waiver eligibility are as follows:

   a. Loss of Financial Eligibility. If the member is determined to be financially ineligible, their enrollment will end concurrent with Medicaid eligibility as described in Addendum I.
   b. Loss of Functional Eligibility. If the member is determined to be functionally ineligible, CCP will notify the appropriate county Economic Support worker within five (5) days. Eligibility will cease as described in Addendum I.
   c. Out of Area Residence. If the member moves permanently out of the catchment area, the date of disenrollment shall be the date when the move occurs. The Department will recoup capitation payment to reflect a mid-month disenrollment and will continue to recoup any whole capitation payments made for months subsequent to the month an out of area move occurs.
   d. Death. If the member dies, the date of disenrollment shall be the date of death. The Department will recoup capitation payment to reflect a mid-month disenrollment and will continue to recoup any whole capitation payments made for months subsequent to the month a member dies.

2. Notification to the Member. When CCP notifies the County and Medicare enrollment agencies of the loss of waiver eligibility, CCP shall also send written notification to the member. This written notification shall include:

   a. A statement that the member is no longer eligible for the Partnership program;
   b. The reason(s) for the loss of waiver eligibility; and
   c. The phone number of the County Economic Support Worker if Medicaid eligibility was established through the County or the Social Security Administration if the person has SSI.

G. Re-Enrollment and Transition Out of CCP

1. All re-enrollments will be treated as new enrollments except that when a member re-enrolls within two months after losing waiver eligibility, that member's re-enrollment will not be treated as a new enrollment.

2. CCP shall assist participants whose enrollment ceases for any reason in obtaining necessary transitional care through appropriate referrals, by making medical records available to the participants' new providers; and (if applicable) by working with the Department to reinstate participants' benefits in the FFS system.

## ARTICLE VIII

## MEMBER RIGHTS

*Contents:*



A. Outcome

CCP safeguards its members' rights. The outcome is met when CCP follows its written policies and procedures in place to designate and protect the rights of its members. Those policies and procedures must include, at a minimum, items C. through D., below.

B. Member Rights and Responsibilities

CCP shall have in effect written safeguards of the rights of enrolled participants, including a member bill of rights, in accordance with regulations and with other requirements of 42 CFR 438.100, Enrollee Rights and Protections, and of Federal and State laws that are designed for the protection of Partnership members.

C. Advance Directives

CCP must maintain written policies and procedures regarding advance directives. An advance directive is a written instruction, such as a living will or durable power of attorney for health care, recognized under Wisconsin law (whether statutory or recognized by the courts of Wisconsin) and relating to the provision of such care when the individual is incapacitated.

1. Written Information. CCP shall provide written information at the time of enrollment and periodically thereafter to reflect changes in State laws as soon as possible but within ninety (90) days of any changes regarding:

    a. The individual's rights under Wisconsin law (whether statutory or recognized by the courts of Wisconsin) to make decisions concerning such medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives;
    b. CCP's written policies respecting the implementation of such rights; and
    c. Participant right to complain to the Department of failures by CCP to comply with advance directives.

2. Documentation. CCP shall document in the participant's medical records whether or not the participant has executed an advance directive.

3. Fair Treatment. CCP shall not establish any conditions in the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive. This provision shall not be construed as requiring the provision of care which conflicts with an advance directive.

4. Compliance. CCP shall ensure compliance with requirements of Wisconsin law (whether statutory or recognized by the courts of Wisconsin) respecting advance directives.

5. Education. CCP shall provide education for CCP staff and members on issues concerning advance directives.

6. Right to Object. The above provisions shall not be construed to prohibit the application of any Wisconsin law which allows for an objection on the basis of conscience for any health care provider or any agent of such provider which as a matter of conscience cannot implement an advance directive.

D. Provision of Interpreters

Provide interpreter services for members, as necessary, to ensure availability of effective communication regarding treatment, medical history or health education.

1. Access to Interpreters. Furthermore, CCP must provide for twenty-four (24) hour a day, seven (7) days a week access to interpreters conversant in languages spoken by the population in CCP's service area including at least Spanish and Hmong. Also, upon a recipient or provider request for interpreter services in a specific situation where care is needed, CCP shall make all reasonable efforts to acquire an interpreter in time to assist adequately with all necessary care, including urgent and emergency care.

2. Documenting Services. CCP must routinely document all such efforts. This documentation must be available to the Department at the Department's request.

3. Professional Interpreters. Professional interpreters shall be used when needed where technical, medical, or treatment information is to be discussed, or where use of a family member or friend as interpreter is inappropriate.

4. Family Members as Interpreters. Family members, especially children, should not be used as interpreters in assessments, therapy and other situations where impartiality is critical.

5. Active List of Interpreters. CCP will maintain a current list of interpreters who are "on call" status to provide interpreter services. The list shall include experts in American Sign Language. Provision of interpreter services must be in compliance with Title VI of the Civil Rights Act.

## ARTICLE IX

## COMPLAINTS AND APPEALS

*Contents:*



A. Outcome

CCP has and follows complaint and appeals policies and procedures which comply with applicable State and Federal requirements.

Outcome is met when:

1. CCP abides by the provision of this article;

2. CCP has developed and implemented complaint and appeals policies and procedures that comply with applicable State and Federal requirements. These policies and procedures shall be provided to the Department upon request; and

3. CCP has submitted quarterly complaints and appeals reports per the requirements in Addendum IV of this contract.

B. Definitions

As used in this Article, the following terms have the indicated meanings:

1. An "Action" is:

   a. The denial or limited authorization of a requested service, including the type or level of service;
   b. The reduction, suspension, or termination of a previously authorized service;
   c. The denial, in whole or in part, of payment for a service;

d. The failure to provide services in a timely manner, as defined by the State; or
e. The failure of CCP to act within the timeframes provided in 42 CFR 438.408(b).

2. An "appeal" is a request for review of an "action."

3. A "complaint" is an expression of an enrollee's dissatisfaction about any matter other than an "action."

C. General Requirements for Complaints

1. CCP must have a system in place for enrollees that includes a CCP complaint process that also provides access to the Department's complaint process.

2. Filing requirements – Authority to file.

An enrollee or an enrollee's legal representative or anyone acting on the enrollee's behalf with the enrollee's written permission may file a complaint to CCP or to the Department.

3. Filing requirements – Timing – Those who have authority to file a complaint, as specified above, can file a complaint to CCP or the Department at any time.

4. Procedures.

a. An individual with authority may file a complaint either orally or in writing with CCP and/or in writing-only to the Department. CCP must attempt to resolve all oral complaints informally.
b. All complaints, whether they are resolved informally or formally, must be documented by CCP.
c. CCP must follow the complaint procedures discussed in its Member Handbook.

D. General Requirements for Appeals

1. CCP must have a system in place for enrollees that includes a CCP appeal process that provides access to a Department process and a fair hearings process at the Department of Administration/Division of Hearings and Appeals (DHA).

2. Filing requirements – Authority to file.

An enrollee or an enrollee's legal representative or anyone acting on the enrollee's behalf with the enrollee's written permission can file an appeal to CCP, to the Department, and/or to the DHA. A provider may also file an appeal on behalf of an enrollee to the parties listed above.

3. Filing requirements – Timing – Those who have authority to file an appeal, as specified above, must file an appeal to CCP or the Department or request a fair hearing with the DHA within forty-five (45) days of CCP's notice of action.

4. Procedures.

a. An individual with "authority to file" can file an appeal either orally or in writing with the Department and/or CCP or can request a fair hearing with the DHA, and unless he or she requests expedited resolution, must follow an oral filing with a written, signed appeal.
b. All appeals must be documented and adjudicated as required in this article.
c. CCP must follow the appeal procedures discussed in its Member Handbook.

E. Notice of Action and Appeal Rights

1. CCP must provide a notice of action to affected members when CCP applies or intends on applying an "action" as defined in Section B., above.

2. Language and format requirements. A notice of any "action" provided to an enrollee must be in writing, with oral interpretation available, and must meet the language and format requirements of 42 CFR 438.10(c) and (d) to ensure ease of understanding.

The notice must explain the following:

a. The action CCP or its contractor has taken or intends to take.
b. The reasons for the action.
c. The right of the person with authority to file to appeal to CCP and/or the Department in regard to the "action."
d. The right of the person with authority to file to request a fair hearing with the DHA simultaneous with, or in any order in regard to, CCP and Department appeals.
e. The enrollee's right to request the assistance of the Managed Care Ombuds.
f. The procedures for exercising the rights specified in this paragraph, including appropriate phone numbers and addresses.
g. The circumstances under which expedited resolution is available and how to request it.
h. The enrollee's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the enrollee may be required to pay the costs of these services.

3. Timing of notice. CCP must mail the notice within the following timeframes:

a. For termination, suspension, or reduction of previously authorized Medicaid-covered services, within the timeframes specified in 42 CFR 431.211, 431.213, and 431.214.
b. For denial of payment, at the time of any action affecting the claim.

c. For standard service authorization decisions that deny or limit services, within the timeframe specified in 42 CFR 438.210(d)(l).
d. For service authorization decisions not reached within the timeframes specified in 42 CFR 438.210(d) (which constitutes a denial and is thus an adverse action), on the date that the timeframes expire.
e. For expedited service authorization decisions, within the timeframes specified in 42 CFR 438.210(d).

4. If CCP extends the timeframe to authorize a service or provide notice in accordance with 42 CFR 438.210(d)(l), it must:

a. Give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file an appeal if he or she disagrees with that decision; and
b. Issue and carry out its determination as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.

F. Handling of Complaints and Appeals

General requirements. In handling complaints and appeals, CCP must meet the following requirements:

1. Give enrollees any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

2. Acknowledge receipt of each complaint and appeal.

3. Ensure that the individuals who make decisions on complaints and appeals are individuals:

a. Who were not involved in any previous level of review or decision making regarding an "action," and,
b. Who, if deciding any of the following, are health care professionals who have the appropriate clinical expertise, as determined by the State, in treating the enrollee's condition or disease:
    i. An appeal of an "action" that is based on lack of medical necessity.
    ii. An appeal regarding denial of expedited resolution of an appeal.
    iii. A complaint or appeal that involves clinical issues.

G. Special Requirements for Appeals

The process for appeals must:

1. Provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in

writing, unless the individual with authority to file requests expedited resolution.

2. Provide the enrollee a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. (CCP must inform the enrollee of the limited time available for this in the case of expedited resolution.)

3. Provide the enrollee and his or her representative an opportunity, before and during the appeals process, to examine the enrollee's case file, including medical records, and any other documents and records considered during the appeals process.

4. Provide the following persons a reasonable opportunity to be parties to the appeal:

    a. The enrollee and his or her representative; or
    b. The legal representative of a deceased enrollee's estate.

H. Basic Rule of Complaints and Appeals

CCP must dispose of each complaint and resolve each appeal, and provide a final decision, as expeditiously as the enrollee's health condition requires, within State established timeframes that may not exceed the timeframes specified in this Article.

I. Timeframes for Complaints and Appeals

1. Standard disposition of a complaint. For standard disposition of a complaint and final decision to the affected parties, the timeframe is ninety (90) days from the day CCP receives the complaint.

2. Standard resolution of appeals. For standard resolution of an appeal and final decision to affected parties, the timeframe is forty- five (45) days from the day CCP receives the appeal. This timeframe may be extended as described in Section J. 1. of this article.

3. Expedited resolution of appeals. For expedited resolution of an appeal and notice to affected parties, the timeframe is three (3) calendar days after CCP receives the appeal. This timeframe may be extended as described in Section J. 2. of this article.

J. Extension of Appeals Timeframes

1. CCP may extend the timeframes of standard appeals as specified in Section I. 2., above, by up to fourteen (14) calendar days if:

    a. The enrollee or the enrollee's representative requests the extension; or
    b. CCP shows (to the satisfaction of the Department, upon its request) that there is need for additional information and that a delay is in the enrollee's best interest.

2. CCP may extend the three (3) calendar day timeframe of expedited appeals up to a total of fourteen (14) calendar days if either of the criteria specified above in Section J.1.a. and b. are met.

3. Requirements following extension. If CCP extends the timeframes, it must, for any extension not requested by the enrollee or the enrollee's representative, give the enrollee and/or representative written notice of the reason for the delay.

K. Resolution of Appeals

1. CCP will use the following method to notify an enrollee and/or an enrollee's representative of the resolution of an appeal.

    a. CCP must provide the appeal resolution in writing within forty-five (45) days of the receipt of the appeal.
    b. For an expedited resolution, CCP must also make reasonable efforts to provide the resolution orally.
    c. Content of appeal resolution. The written resolution must include the following:
        i. The results of the resolution process and the date it was completed.
        ii. For appeals not resolved wholly in favor of the enrollees:
            (a) The right to appeal to the Department and/or to request a fair hearing with the DHA, and how to do so;
            (b) The right to request to receive benefits while the hearing is pending, and how to make the request; and
            (c) That the enrollee may be held liable for the cost of those benefits if the Department or DHA upholds CCP's action.

2. Requirements for State fair hearings.

    a. The State must permit the enrollee to request a fair hearing with the DHA within forty-five (45) days from the date of CCP's notice of action.
    b. The parties to the fair hearing include CCP, the Department, as well as the enrollee and the individual with authority to file or the representative of a deceased enrollee's estate.

3. Expedited resolution of appeals.

    a. General Rule. CCP must establish and maintain an expedited review process for appeals, when CCP determines (in regard to a request from the enrollee) or the provider indicates (in making the request on the enrollee's behalf or supporting the enrollee's request) that taking the time for a standard resolution could seriously jeopardize the enrollee's life, health, or ability to attain, maintain, or regain maximum function.

b. Punitive Action. CCP must ensure that punitive action is not taken against the provider or the individual who requests an expedited resolution or supports an enrollee's appeal.
c. If CCP denies a request for expedited resolution of an appeal, it must:
    i. Transfer the appeal to the timeframe for standard resolution in accordance with section I. 2., above; and
    ii. Make reasonable efforts to give the enrollee prompt oral notice of the denial, and follow up within two (2) calendar days with a written notice.

4. Reversed appeal resolutions.

a. Services not furnished while the appeal is pending. If CCP, the Department, or the DHA reverses a decision to deny, limit, or delay services that were not furnished during the appeal, CCP must authorize or provide the disputed services promptly, and as expeditiously as the enrollee's health condition requires.
b. Services furnished while the appeal is pending (See Section L, below). If CCP, the Department, or the DHA reverses a decision to deny authorization of services, and the enrollee received the disputed services during the appeal, CCP or the Department must pay for those services in accordance with Department policy and regulations.

L. Continuation of Benefits During Appeals

1. Terminology. As used in this section, "timely" filing means filing on or before the later of the following:

a. Within ten (10) days of CCP's mailing the notice of action.
b. The intended effective date of CCP's proposed action.

2. Continuation of benefits. CCP must continue the enrollee's benefits if:

a. The enrollee or representative files the appeal timely;
b. The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
c. The services were ordered by an authorized provider;
d. The original period covered by the original authorization has not expired; and
e. The enrollee requests extension of benefits.

3. Duration of continued or reinstated benefits.

If, at the enrollee's request, CCP continues or reinstates the enrollee's benefits while the appeal is pending, the benefits must be continued until one of the following occurs:

a. The enrollee or representative withdraws the appeal.
b. Ten (10) days pass after CCP mails the resolution of the appeal against the enrollee, unless the enrollee or representative, within the ten (10) day timeframe, has requested:
    i. An appeal with the Department or a State fair hearing with the DHA; and
    ii. Continuation of benefits until a Department or DHA decision is reached.
c. The Department or DHA issues a decision adverse to the enrollee.
d. The time period or service limits of a previously authorized service has been met.

4. Enrollee responsibility for services furnished while the appeal is pending. If the final resolution of the appeal is adverse to the enrollee, that is, upholds CCP's action, CCP or its providers may recover the cost of services furnished to the enrollee while the appeal is pending, to the extent that they were furnished solely because of the requirements of this section, and in accordance with the policy set forth in 42 CFR 431.230(b).

M. Record Keeping and Reporting Requirements

1. CCP must maintain records of complaints and appeals.

2. CCP must report complaints and appeals to the Department on a quarterly basis per the requirements in Addendum IV of this contract.

## ARTICLE X

## QUALITY ASSURANCE / QUALITY IMPROVEMENT (QA/QI) AND EXTERNAL REVIEW

*Contents:*



A. Outcome

Ensure the ongoing quality assessment and performance improvement of services provided to program participants.

1. The outcome is met when CCP:

    a. Demonstrates that it has an internal quality improvement system described in an annual report to the Department;
    b. Provides documentation that it has reviewed and if appropriate, taken steps for improving the quality of services provided by subcontractors as reported in the annual delegation of authority report to the Department;
    c. Provides documentation that it has reviewed and if appropriate, taken steps for improving, access to health care in an annual report to the Department;
    d. Provides documentation of the results of physician credentialing in an annual report to the Department;
    e. Provides the results of member satisfaction survey indicating overall satisfaction of at least eighty (80) percent in an annual report to the Department;
    f. Achieves demonstrable improvement in significant aspects of clinical and non-clinical care areas that can be expected to have a favorable effect on health outcomes and participant satisfaction, as evidenced in the two annual project reports to the Department; and
    g. Demonstrates improvement in the support provided to consumers in achieving their desired outcomes. Improvements will be measured using the baselines established in the Member Outcomes Assessment report of July 2001. Target improvement levels are as follows: an improvement of five (5) percentage

points in the levels of support achieved in areas where support was present less than eighty (80) percent of the time. (Where levels of support were seventy-five (75) percent to seventy-nine (79) percent, improvement to the support being present eighty (80) percent of the time will be sufficient to meet this outcome.)

B. QA/QI Regulations

1. General Medicaid Requirements. Comply with Medicaid regulations which require a Quality Improvement system that:

   a. Is consistent with the utilization control requirement of 42 CFR 456, Utilization Control;
   b. Has appropriate health professionals reviewing the provision of health services;
   c. Provides for systematic data collection of performance and patient results;
   d. Provides for interpretation of this data to the practitioners; and
   e. Provides for making needed changes.

   *42 CFR 438.242(a) Health Information Systems- collecting, analyzing, integrating & reporting data

C. QA/QI Program

Program. CCP must have a comprehensive QA/QI program that protects, maintains, and improves the quality of care provided to Medicaid and Medicare program recipients. CCP must evaluate the overall effectiveness of its QA/QI program annually to determine whether the program has demonstrated improvement, where needed, in the quality of care and service provided to its population. CCP must describe the QA/QI committee and its activities in an annual report to the Department.
*42 CFR 438.240(a)(1) QI Program in Place

D. QA/QI Monitoring and Evaluation

1. Guidelines and Quality Indicators. CCP agrees to submit required data for the PACE/Partnership Mini Encounter Database and the PACE/Partnership Intake, Enrollment & Event Database. This data will be used to identify areas for external quality review and provide information for further quality improvement. The primary indicator of consideration will be in the area of ambulatory care sensitive conditions (ACSC) and CCP's ability to manage the care of members with ACSC's in the community.

   *42 CFR 438.240(a)(2) CMS and State Performance Measures
   *42 CFR 438.240(b)(1) Health Information Systems- Encounter Data

2. QA/QI Priority Areas. CCP must also monitor and evaluate care and services in certain priority health and psychosocial areas of interest specified by the Department.

3. QA/QI Studies. CCP must make documentation available to the Department upon request regarding QA/QI and assessment studies on plan performance which relate to the Medicaid population.

*42 CFR 438.240(b)(2), and (c): Elements of State Quality Strategy

E. QA/QI Access to Health Care

1. Demonstrate that enrolled recipients have access to screening, diagnosis and referral, and appropriate treatment for those conditions and services covered under Partnership.

2. Written Standards. CCP must have written standards for the accessibility of care and services, which are communicated to providers and monitored. The standards must include the following:

    a. Waiting times for care at facilities;
    b. Waiting times for appointments;
    c. A statement that providers' hours of operation do not discriminate against Medicaid enrollees; and
    d. A statement specifying whether or not providers speak members' languages.

F. QA/QI Provider Selection and Evaluation

1. Written Policies. CCP must have written policies and procedures for provider selection and qualifications.

2. CCP must periodically monitor (no less than every three years) the physician's documented qualifications to assure that the physician still meets CCP's specific professional requirements.

3. CCP's professional accreditation requirements may not exclude culturally diverse behavioral health providers or subcontractors.

4. Notification to Department. In addition to the requirements in this section, CCP must immediately forward to the Department the names of physicians who have been terminated from CCP physician network as a result of quality issues.

G. QA/QI Members' Feedback

1. Communication Processes. CCP must have a process(s) to maintain a relationship with its members that promotes two-way communication and contributes to quality of care and services. CCP shall demonstrate a commitment to treat members with respect and dignity and to involve members in QA/QI initiatives.

2. Member Feedback. Some methods to receive member feedback include: focus groups, consumer advisory councils, member participation on the governing board, the QA/QI committee or other committees; or task forces related to evaluating services. Documentation of efforts to solicit feedback from Partnership members must be available to the Department upon request.

H. QA/QI Utilization Management (UM)

Documented Policies. CCP must have documented policies and procedures for utilization review that reflect current standards of medical practice in processing requests for initial or continued authorization of services. CCP must also have in effect mechanisms to detect both under-utilization and over-utilization of services.
*42 CFR 438.240(b)(3) Over and Under Utilization of Services

I. QA/QI External Quality Review

External Quality Review Organization (EQRO) for Medicaid and Medicare. CCP must assist the Department and the external quality review organization under contract with the Department in identifying and collecting information required to carry out on-site or off-site medical chart reviews, interviews with care teams and members. The EQRO will review care management practices surrounding the care and treatment of ACSCs. The EQRO will also be reviewing records to validate data submitted to the Department. Finally, the EQRO will be reviewing data collected by the Department and its contractors to assess CCP's compliance with Medicaid regulations and this contract.
*42 CFR 438.204(e)(2) Program Review

J. Annual QA/QI Studies and Indicators

1. Annual Survey. Annually, CCP shall internally survey a representative sample of its enrolled members to identify their level of satisfaction with CCP's services. The survey's purpose is to identify potential problems and barriers to care. CCP shall have a system in place for acting on survey results.

2. Two Annual Performance Improvement Projects. CCP may select two areas of study from the lists for Annual Performance Improvement Projects that the Department has recommended for the Partnership program. CCP may select studies not on these lists; however study topics not on the recommended lists are subject to Department approval.

3. Cooperation with CMS and the Department. CCP shall cooperate with CMS and the Department to conduct studies and surveys as part of the demonstration program evaluation.

4. Semiannual Progress Reports. CCP will report to the Department on its progress twice per year. Reports shall be in writing and my include:

a. Accomplishments;
b. Utilization Management;
c. Staff Development;
d. Marketing;
e. Special Studies Conducted, if any;
f. Barriers and Solutions; and
g. Plans for Next Quarter.
*42 CFR 438.240(b)(1), (d)(1) Performance Improvement Projects
*42 CFR 438.240(d)(2) Performance Improvement Projects – Timeline for Completion

## ARTICLE XI

## HUMAN RESOURCES

*Contents:*



A. Outcome

CCP uses qualified staff and does not discriminate in staffing and in service delivery.

1. Outcome is met when CCP:

    a. Complies with the applicable laws and legislation in Section B of this article and the references listed therein; and
    b. Demonstrates compliance through submission of the following reports and/or updates to the Department per the Reporting Requirements in Addendum IV:
        i. Civil Rights Compliance Plan with Workforce Analysis.

2. These plans are considered approved by the Department's Affirmative Action/Civil Rights Compliance (AA/CRC) Office, unless the AA/CRC Office informs CCP otherwise.

B. Applicable Laws and Legislation

1. CCP shall comply with all applicable Federal and State laws and legislation relating to the outcome including:

    * § 16.765, Wis. Stats. – Nondiscriminatory Contracts.
    *Federal Civil Rights Act of 1964 and regulations issued pursuant to that Act and the provisions of Federal Executive Order 11246 dated September 26, 1985
    *Section 504 of the Federal Rehabilitation Act of 1973, as amended (29 U.S.C. 794).
    *45 CFR Part 84 and all guidelines and interpretations issued pursuant thereto.
    *Age Discrimination and Employment Act of 1967.
    *Age Discrimination Act of 1975.
    *Caregiver Law of 1998.
    *See Addendum VII, Compliance Agreement, Affirmative Action/Civil Rights, for other pertinent legislation.

## ARTICLE XII

## INFORMATION ACCESS AND SECURITY

*Contents:*



A. Outcome

CCP maintains and has safeguards in place regarding use of, access to, and protection from unauthorized disclosure of all protected health information as defined in 45 CFR 164.501.

Outcome is met when CCP:

1. Complies with Sections B and C of this article and the references therein.

B. Applicable Laws and Legislation

CCP shall comply with all applicable Federal and State laws relating to the outcome including:

1. Health Insurance Portability and Accountability Act of 1996 (HIPAA) and regulations issued pursuant to that Act, including:

   *45 CFR Part 142;
   *45 CFR Parts 160 through 164;
   *Balanced Budget Amendment of 1997, S. 438.324, "Confidentiality;"
   *42 CFR 431 Subpart F, "Safeguarding Information on Applicants and Recipients;"
   *HFS 104.01(3), Wis. Admin. Code; - Confidentiality of Medical Information;
   *HFS 105.02(1)-(7), Wis. Admin. Code; - Requirements for Maintaining Certification;
   *HFS 106.02(9)(b), "Medical and Financial Recordkeeping," Wis. Adm. Code;
   *HFS 107.32(1)(d), "Case Management Services," Wis. Admin. Code;
   *HFS 108.01, "Safeguarded Information," Wis. Admin. Code.

C. Other Specific Requirements

1. CCP agrees to forward to the Department all media contacts regarding Medicaid enrollees for the Medicaid program.

2. CCP shall use its best efforts to assist enrollees and their authorized representatives in obtaining complete records within ten (10) working days of the record request.

3. Records Access

a. Records Retention. CCP shall retain, preserve and make available upon request all records relating to the performance of its obligations under this contract, including claim forms, for not less than six (6) years following the end of this contract period. Records involving matters which are the subject of an audit or litigation shall be retained for a period of not less than six (6) years following the termination of the audit or litigation. Microfilm copies of the documents contemplated herein may be substituted for the originals with the prior written consent of the Department, provided that the microfilming procedures are approved by the Department as reliable and are supported by an effective retrieval system. Upon expiration of the six (6) year retention period, the subject records shall, upon request, be transferred to the Department's possession. No records shall be destroyed or otherwise disposed of without the prior written consent of the Department.

b. General Access Requirements. CCP shall allow the Department and CMS, or their duly authorized agents or representatives, during normal business hours, access to CCP's premises or CCP subcontractor's premises to inspect, audit, monitor or otherwise evaluate the performance of CCP's or subcontractor's contractual activities and shall forthwith produce all records requested as part of such review or audit. Such access shall be maintained through six (6) years from the final date of this contract period or completion of any audit, whichever is later. Access will also include the right to reproduce all such records and material and to verify reports furnished in compliance with the provisions of the Contract.

c. Financial Records. CCP and any subcontractors shall make available to the Department, the Department's authorized agents, and appropriate representatives of the U.S. DHHS any financial records of CCP or subcontractors which relate to CCP's capacity to bear the risk of potential financial losses, or to the services performed and amounts paid or payable under this contract.

d. Requests for Access. In the event right of access is requested under this article, CCP or subcontractor shall, upon request, provide and make available staff to assist in the audit or inspection effort, and provide adequate space on the premises to reasonably accommodate the duly authorized State or Federal representatives conducting the audit or inspection effort. All inspections or audits shall be conducted in a manner that will not unduly interfere with the performance of CCP's or subcontractor's activities.

e. Findings. CCP will be given fifteen (15) business days to respond to any findings of an audit before the Department shall finalize its findings. All information so obtained will be accorded confidential treatment as provided under applicable law.

## ARTICLE XIII

## PAYMENT TO COMMUNITY CARE PARTNERSHIP

*Contents:*



A. Outcome

The Department shall ensure that CCP receives defined prospective capitation payments for each enrolled member and, where specified, receive adjusted capitation payment or reimbursement for expenses exceeding capitation rates.

B. Medicaid Capitation Rates

In full consideration of contract outcomes delivered by CCP, the Department agrees to pay CCP monthly payments based on the capitation rate specified in Addendum VI, Actuarial Basis.

1. Methodology. The capitation rate shall be prospectively designed to be less than the cost of providing the same services covered under this contract to a comparable Medicaid population on a FFS basis. The capitation rate is calculated on an actuarial basis recognizing the payment limits set forth in 42 CFR 438.69(c).

C. Special Capitation for Intensive Skilled Nursing Level (ISN) of Care

1. ISN Capitation Payments. When LTC Functional Screen, or other means approved by the Department, determines that members are at an ISN level of care, CCP will receive monthly capitation payments for each member qualified for ISN: Provisional Phase-In. If there is an initial period when the capitation rate cannot be delivered on a monthly basis, CCP will submit a report, within sixty (60) days at the end of the contract, on the total number of ISN enrollment days, the Medicaid ID number of ISN qualified members, and other relevant data as specified by the Department. The Department will conduct a year-end payment adjustment for persons who have been determined to be at the ISN level of care during the contract year. Payments will be made based on the data submitted by CCP and on the Department's eligibility data.
2. Department's Authority. The Wisconsin LTC Functional Screen, or other means approved by the Department, will be used to determine when a member's health status

qualifies to receive Intensive Skilled Nursing level of care. CCP may conduct a LTC-Functional Screen at any time to determine if a member is at an ISN level of care.

3. Date of Initial Determination and ISN Capitation Payment. A member becomes eligible for the ISN capitation rate when it is determined through the LTC Functional Screen, or other means approved by the Department, that the member qualifies for ISN level of care and that information is provided to the county Economic Support Worker.

4. Termination. When it is determined that a member no longer qualifies for ISN level of care, the Department will terminate the member's ISN capitation payments and reactivate the appropriate capitation rate. The Department will conduct a year-end payment adjustment for those members whose ISN levels of care have changed.

5. Reporting ISN Cases. CCP shall submit additional reports on the following ISN activities to the Center for Delivery Systems Development according to the schedule indicated in Addendum IV, Reporting Requirements, of the contract.

    a. Reporting Changes in ISN Cases. CCP shall inform the county Economic Support Worker and the Center for Delivery System Development when a member no longer meets the ISN level of care. The Department will suspend the member's ISN capitation payment and reactivate the capitation rate due to CCP participants. The Department may apply sanctions for CCP's willful failure to re-determine the level of care of ISN members or to inform the Department about the re-determination.

D. Renegotiation

The monthly capitation rates set forth in this article shall not be subject to renegotiation during the contract term or retroactively after the contract term, unless such renegotiation is required by changes in Federal or State law.

E. Payment Schedule

Payment to CCP shall be based on CCP Enrollment Reports which the Department will transmit to CCP. The Department will issue payments for each person listed as an ADD or CONTINUE in the CCP Enrollment Reports within sixty (60) days of the date the report is generated. CCP shall accept payments under this contract as payment in full and shall not bill, charge, collect or receive any other form of payment from the Department and the participant except as permitted by Medicaid regulations and agreements with the Department concerning 1115 waivers and post eligibility treatment of income.

F. Coordination of Benefits

1. CCP shall actively pursue, collect and retain any monies from third party payers for services to enrollees covered under this contract except where the amount of reimbursement CCP can reasonably expect to receive is less than the estimated cost of recovery (this exemption does not apply to Third Party Liability (TPL) collections

for AIDS and ventilator dependent patients), or except as provided in Addendum II, Policy Guidelines on Community-Based Programs.

2. Cost effectiveness of recovery is determined by, but not limited to time, effort, and capital outlay required to perform the activity. CCP must be able to specify the threshold amount or other guidelines used in determining whether to seek reimbursement from a liable third party, or describe the process by which CCP determines seeking reimbursement would not be cost effective, upon request of the Department.

3. To assure compliance, records shall be maintained by CCP of all COB collections and reports shall be made quarterly on the form designated by the Department in Addendum V, COB Report Format. CCP must be able to demonstrate that appropriate collection efforts and appropriate recovery actions were pursued. The Department has the right to review all billing histories and other data related to COB activities for enrollees. CCP must seek from all enrollees information on other available resources. Other available resources may include, but are not limited to, group or individual health insurance, ERISAs, service benefit plans, and subrogation/workers compensation collections.

   Subrogation collections are any recoverable amounts arising out of settlement of personal injury, medical malpractice, product liability, or Worker's Compensation. State subrogation rights have been extended to CCP under s. 49.89(9), Wis. Stats. After attorneys' fees and expenses have been paid, CCP shall collect the full amount paid on behalf of the enrollee.

   CCP must also seek to coordinate benefits before claiming reimbursement from the Department for the AIDS and ventilator dependent enrollees.

4. Section 1912(b) of the Social Security Act must be construed in a beneficiary-specific manner. The purpose of the distribution provision is to permit the beneficiary to retain TPL benefits to which he or she is entitled to except to the extent that Medicaid (or CCP on behalf of Medicaid) is reimbursed for its costs. CCP is free, within the constraints of State law and this contract, to make whatever case it can to recover the costs it incurred on behalf of its enrollee. It can use the Medicaid fee schedule, an estimate of what a capitated physician would charge on a FFS basis, the value of the care provided in the market place or some other acceptable proxy as the basis of recovery. However, any excess recovery, over and above the cost of care (however CCP chooses to define that cost), must be returned to the beneficiary. CCP is to follow the practices outlined in the Department's Casualty Recovery Manual.

5. Personal Injury Settlements. When CCP is aware of personal injury case settlements, CCP will submit any information regarding such settlement to the Department as soon as practical. CCP may use the form attached as Addendum VIII, Personal Injury Settlements, for reporting these settlements.

6. COB collections are the responsibility of CCP or its subcontractors. Subcontractors must report COB information to CCP. CCP and subcontractors shall not pursue collection from the enrollee, but directly from the third party payer. Access to medical services will not be restricted due to COB collection.

7. The following requirement shall apply if CCP (or CCP's parent firm and/or any subdivision or subsidiary of either CCP's parent firm or of CCP) is a health care insurer (including, but not limited to, a group health insurer and/or health maintenance organization) licensed by the Wisconsin Office of the Commissioner of Insurance and/or a third-party administrator for a group or individual health insurer(s), health maintenance organizations(s), and/or employer self-insurer health plan(s):

    a. Throughout the Contract term, these insurers and third-party administrators shall comply in full with the provision of s. 49.475 of the Wis. Statutes. Such compliance shall include the routine provision of information to the Department in a manner and electronic format prescribed by the Department and based on a monthly schedule established by the Department. The type of information provided shall be consistent with the Department's written specifications.
    b. Throughout the Contract term, these insurers and third-party administrators shall also accept and properly process post-payment billings from the Department's fiscal agent for health care services and items received by Wisconsin Medicaid enrollees.

G. Recoupments

The Department will not normally recoup CCP per capita payments when CCP actually provided service or due to subsequent ineligibility determination. However, the Department may recoup CCP capitation payments in the following situations:

1. Change in Participant's Status.

    a. The department will recoup CCP's capitation payments for the following situations when a member's eligibility status has changed before the first day of a month for which a capitation payment has been made:
        i. The member moves out of CCP's service area;
        ii. The member enters a public institution; or
        iii. The member dies.
    b. The Department will recoup CCP's capitation payments for the following situations when the Department initiates a change in a member's status on a retroactive basis, reflecting the fact that CCP was not able to provide services. In these situations, recoupments for multiple-month capitation payments are more likely:
        i. Correction of a computer or human error, where the person was never really enrolled in CCP; and

ii. Disenrollments of members.

2. Disputed Membership. When membership is disputed between two contractors, the department shall be the final arbitrator of membership and reserves the right to recoup an inappropriate capitation payment.

3. Contract Termination. If a contract is terminated, recoupments will be handled through a payment by CCP within thirty (30) days of contract termination.

H. Adjustments

The Department will make a retrospective payment adjustment whenever:

1. The actual enrollment months by age does not match the projected enrollment by age cohort used for rate setting purposes.

2. The actual nursing home level of care distribution does not match the projected nursing home level of care distribution used for rate setting purposes.

3. The proportion of enrollees who are dually eligible for both Medicare and Medicaid coverage does not match the projected distribution of Medicare and/or Medicaid eligible for rate setting purposes.

4. Payments for the adjustments will take place within the first quarter of the year after receipt of the certified cost report required by Article XIV, B, 7, Annual Report.

I. Payment for Aids, HIV- Positive, and Ventilator Dependent

The Department will pay CCP's costs of providing Medicaid-covered services provided to CCP enrollees who meet the criteria in this section. These payments will be made based on the date submitted by CCP to the Department on a quarterly basis using the format specified in Addendum XI, AIDS/Ventilator Dependent Report Format. The data submission schedule is included in Addendum IV, Reporting Requirements, of this contract. Reimbursement already provided to CCP for Medicaid costs in the form of capitation payments for qualified enrollees will be deducted from one hundred (100) percent reimbursement payments for Medicaid costs. CCP will retain $41.86 per non-institutionalized day for long-term care services and will remain responsible for those services. The criteria for qualified enrollees are:

1. Ventilator Assisted Patients. Costs incurred for enrollees who need ventilator treatment services qualify for reimbursement if the enrollee meets the following criteria:

a. Criteria. For the purposes of this reimbursement, a ventilator-assisted patient must have died while on total respiratory support or must meet all of the criteria below:

i. The patient must require equipment that provides total respiratory support. This equipment may be a volume ventilator, a negative pressure ventilator, a continuous positive airway pressure (CPAP) system, or a Bi (inspiratory and expiratory) PAP. The patient may need a combination of these systems. Any equipment used only for the treatment of sleep apnea does not qualify as total respiratory support.
ii. The total respiratory support must be required for a total of six or more hours per twenty-four (24) hours.
iii. The patient must have total respiratory support for at least thirty (30) days which need not be continuous.
iv. The patient must have absolute need for the respiratory support as documented by appropriate blood gases.

b. Documentation. CCP will submit the following written documentation to qualify enrollees for reimbursement at the same time as the quarterly report identified in Addendum XI, AIDS/Ventilator Dependent Report Format.
i. A signed statement from the doctor attesting to the need of the patient.
ii. Copies of progress notes which show the need for continuation of total ventilatory support, any change in the type of ventilatory support, and the removal of the ventilatory support.
iii. Copies of lab reports must be submitted if the progress notes do not include blood gas levels.

c. The following methodology will be used to determine months that qualify for enhanced funding:
i. The first qualifying day is the day that the patient is placed on the ventilator. If the patient is on the ventilator for less than six hours on the first day, the use must continue into the next day and be more than six total hours.
ii. Each day that the patient is on the ventilator for a part of any day, as long as it is part of the six total hours per twenty-four (24) hours, counts as a day for enhanced funding.
iii. The period qualifying for enhanced funding starts on the first day of the month that the patient was placed on ventilator support. It ends on the last day of the month after which the patient is removed from the ventilatory support, or at the end of the hospital stay, whichever is later.

2. AIDS or HIV-Positive with Anti Retroviral Drug Treatment. Costs for services provided to enrollees with a confirmed diagnosis of AIDS, as indicated by an ICD9-CM diagnosis code or who are HIV-Positive, qualify for reimbursement if the enrollees are on Anti Retroviral Drug treatment approved by the Federal Drug Administration. Written requests to qualify enrollees for reimbursement must be submitted by CCP to the Department's fiscal agent. These requests should be batched and submitted with the report identified in Addendum XI, AIDS/Ventilator Dependent Report Format. A signed statement from a physician that indicates a

diagnosis of AIDS or HIV-Positive and that the patient is on an Anti Retroviral Drug treatment must accompany each request. One hundred percent reimbursement of Medicaid costs will be effective for services provided on or after the first day of the month in which treatment begins.

For AIDS and HIV-Positive members retroactively disenrolled under Article VIII, Enrollment and Disenrollment Systems, of the contract, CCP will have to back out of the care provided during the backdated period from the report in Addendum XI, AIDS/Ventilator Dependent Report Format.

3. Submission of Data for Ventilator Assistance and AIDS Treatment. As required by Wisconsin law, payment data or adjustment data for for enrollees under paragraph 1. or 2., above, must be received by the Department's fiscal agent within 365 days after the date of the service. If CCP cannot meet this requirement, CCP must provide good cause documentation that substantiates the delay. The Department will make the final determination to waive the three-hundred-sixty-five (365) day billing requirement.

## ARTICLE XIV

## FISCAL PROVISIONS – RISK RESERVE

*Contents:*



A. Outcome

Ensure continuity of care for enrolled members through sound financial management and the deposit of risk reserves necessary to sustain care in the event of insolvency or operating deficits. CCP is responsible for providing care through the period for which capitated payment has been made, as well as for inpatient admissions up until discharge.

The outcome is met when CCP demonstrates that they retain reasonable operating reserves and the minimum risk reserves as described below are on deposit in a segregated account.

B. Risk Reserve for the Partnership Program

1. HMO Licensure. If a Partnership program is licensed as an HMO, the Risk Reserve requirements for HMO licensure will take precedence and supersede sections 2 through 6, and 8, below. The Department may waive, at its discretion, the reporting requirement in section 7 below. The Department may, at its discretion, require copies of any and all reports or correspondence related to HMO licensure.

2. CCP will maintain a balance of thirty (30) days of Medicaid revenue in a Risk Reserve, up to a maximum of $2,000,000.

3. Segregation of Risk Reserve Funds. CCP shall establish and maintain a separate depository or depositories of investment accounts to receive the contributions required under this article. The risk reserve fund account is to be established through State or Federally licensed or chartered organizations in good standing. A maximum of seventy (70) percent may be invested in high-grade securities. If the reserve balance drops below the required level due to fluctuations in the market, CCP will be required to make up the balance from other sources. The funds accumulated in this account are not to be intermingled with other funds of the organization.

4. Excess Revenues. Until the required minimum balance is reached, CCP, throughout the renewal of this contract and at the end of each calendar year, will deposit all unspent Medicaid revenues into the Risk Reserve account.

5. Disbursements. Disbursements may be made from the risk reserve account in order to fund payments to the Department for retrospective adjustments or to fund operating deficits. Prior to withdrawal or disbursement of risk reserve funds, CCP will seek

repayment from stop loss/reinsurance, where applicable. The contractor will discontinue disbursements when the risk reserve fund balance is equal to 25 percent of the balance required under subsection 2 above.

6. Plans to Recover Disbursements. When the contractor withdraws or disburses $10,000 or more during the contract period, the contractor shall notify the Department within ten (10) days of the disbursement. The notification shall include the amount and date of disbursement and indicate how the funds are to be replenished. The contractor shall have a plan, approved by the Department, which specifies the methods and timetable the contractor will employ to replenish the risk reserve fund within forty-five (45) days of the disbursement. Failure to submit an acceptable plan to the Department may subject the contractor to the remedies specified in Article XVI.

   A plan shall not include a timetable exceeding eighteen (18) months. The Department based on existing or additional solvency protections available to the contractor may extend this period.

7. Quarterly Financial Reports. The following reports and calculations must be submitted within forty-five (45) days of the close of each quarter. The submissions of these reports and calculations may be required on a more frequent basis at the discretion of the Department.

   a. Budgeted versus Actual Financial Report, for current and year-to-date periods;
   b. A simplified balance sheet;
   c. A calculation of the current ratio, (Current Assets + Risk Reserve/Current Liabilities);
   d. A calculation of days cash on hand, (Cash + Marketable Securities))/((Operating Expenses – Depreciation)/365);
   e. A calculation of the total debt to net worth ratio, (Current + Long Term Debt)/Net Worth;
   f. Risk Reserve investment summaries on a third party letterhead.

8. Annual Reporting. The contractor's agreement with the depository organization shall include a proviso requiring submission to the Department of annual reports on the status of the risk reserve account and evidence that the outcome is met.

9. CCP agrees to provide the results of an audit, for the prior calendar year, by July 1, which includes:

   a. Results of the annual audit, including "Letters to Management" and any supplemental financial statements, which are part of the annual audit performed by an independent certified public accountant, and
   b. A clear indication of total costs, direct and indirect, related to enrollees, or estimates of total costs that are based on generally accepted accounting principles.

c. CCP shall authorize the independent accountant to allow representatives of the Department, upon written request, to verify the audit report and any supporting work papers and documentation. Supplemental financial statements shall be presented in a form specified by the Department that clearly shows the financial position of CCP in Partnership. These supplemental financial statements may be prepared by CCP.

## ARTICLE XV

## FUNCTIONS AND DUTIES OF THE DEPARTMENT

*Contents:*



A. Outcome

CCP receives timely information and assistance from the Department.

The outcome is met when enrollment reports, feedback on other reports specified within this contract, marketing materials and requests for non-enrollments and requests for involuntary disenrollments are acted on as specified in this contract.

B. Enrollment

Promptly notify CCP of all Medicaid recipients enrolled in CCP under this contract. Notification shall be effected through CCP Enrollment reports. All recipients listed as an ADD or CONTINUE on either the Initial or Final CCP Enrollment Reports are members of CCP during the enrollment month. The reports shall be generated in the sequence specified under CCP Enrollment Reports.

C. Disenrollment

Promptly notify CCP of all Medicaid recipients no longer eligible to receive services through CCP under this contract. Notification shall be effected through CCP Enrollment Reports which the Department will transmit to CCP for each month of coverage throughout the term of the contract. The reports shall be generated in the sequence under CCP Enrollment Reports. Any recipient who was enrolled in CCP in the previous month, but does not appear as an ADD or CONTINUE on either the Initial or Final CCP Enrollment Report for the current enrollment month, is disenrolled from CCP effective the last day of the previous enrollment month.

D. Enrollment Reports

For each month of coverage throughout the term of the contract, the Department shall transmit "CCP Enrollment Reports" to CCP. These reports will provide CCP with ongoing information about its Medicaid enrollees and disenrollees and will be used as the basis for the monthly capitation claims described in Article XIII, Payment to Community Care Partnership. CCP Enrollment Reports will be generated in the following sequence:

1. The Initial CCP Enrollment Report will list all of CCP's enrollees and disenrollees for the enrollment month that are known on the date of report generation. The Initial CCP Enrollment Report will be received by CCP on or before the fifth day of each month covered by the contract. A capitation claim will be generated for each enrollee listed as an ADD or CONTINUE on this report. Enrollees who appear as PENDING on the Initial Report and are reinstated into CCP during the month will appear as a CONTINUE on the Final Report and a capitation will be generated at that time.

2. The final CCP Enrollment Report will list all of CCP's enrollees for the enrollment month who are not included in the Initial CCP Enrollment Report. The final CCP Enrollment Report will be received by CCP on or before the tenth day of each month subsequent to the coverage month. A capitation claim will be generated for each enrollee listed as an ADD or CONTINUE on this report. Enrollees in PENDING status will not be included on the final report.

E. Utilization Review and Control

Waive, to the extent allowed by law, any present Department requirements for prior authorization, second opinions, co-payment, or other Medicaid restrictions for the provision of contract services provided by CCP to enrollees, except as may be provided in Addendum II, Policy Guidelines on Community-Based Programs.

F. Cooperation with CMS

The Department shall cooperate with the Center for Medicare/Medicaid Services in reporting, monitoring, and submitting documentation pertinent to CCP's contractual services and performance.

G. Community Care Partnership Review

Submit to CCP for prior approval materials that describe CCP and that will be distributed by the Department or County to recipients.

H. Review of Study or Audit Results

1. Release to Public. Submit to CCP any studies or audits that are going to be released to the public that are about CCP and Medicaid. The Department will specify a review/comment period of no less than fifteen (15) business days.

2. Department-Initiated Plan of Correction. Under normal circumstances, the Department will not implement a plan of correction prior to CCP's review and response to a preliminary report. The Department may do so, however, if the circumstances warrant immediate action (i.e., if delays may jeopardize or threaten the health, safety, welfare, rights or other interest of participants).

I. Provider Informing

The Department shall continue to inform providers about Medicaid managed care initiatives, including the Partnership program and their contractors.

J. Provider Certification

The Department shall give CCP access to the names and contract information for all MA certified providers in the catchment area; in the alternative, the Department shall continue to give CCP timely responses to CCP's requests for confirmation of particular providers' MA certification status.

## ARTICLE XVI

## REMEDIES FOR VIOLATION, BREACH, OR NON-PERFORMANCE OF CONTRACT

*Contents:*



A. Outcome

The Department and CCP have procedures and criteria in place to remedy contract violations or non-performance.

The outcome is met when the Department and CCP agree to the specifications of this article as evidenced by their signatures on this contract.

B. Medicaid Program – Termination

Either CCP or the Department may terminate this contract pursuant to Article XVII.

In lieu of termination, the Department may also impose "Temporary Management" under the same conditions and timeframes as apply for termination of the contract. All notice periods that apply to termination for non-performance and the corresponding obligations of both CCP and the Department in this Article and Article XVII of the contract also apply to the imposition of temporary management.

C. Medicaid Program – Suspension of New Enrollment

Whenever the Department determines that CCP is out of compliance with this contract, the department may suspend CCP's right to enroll new participants under this contract. The Department, when exercising this option, must notify CCP in writing of its intent to suspend new enrollment at least thirty (30) days prior to the beginning of the suspension period.

The suspension will take effect if the non-compliance remains uncorrected at the end of this period. The Department may suspend new enrollment sooner than the time period specified in this paragraph if the Department finds that participant's health or welfare is jeopardized. The suspension period may be for any length of time specified by the Department, or may be indefinite. The suspension period may extend up to the expiration of the contract.

D. Medicaid Program – Transition

In the case of a participant whose enrollment ceases for any reason, CCP provides assistance to the individual in obtaining necessary transitional care through appropriate referrals and making the individual's medical records available to new providers.

E. Medicaid Program – Withholding of Capitation Payments and Recovery of Damage Costs.

Notwithstanding the provisions of Article XIII, Payment to CCP, the Department may withhold portions of capitation payments or otherwise recover damages from CCP on the following grounds:

1. Failure to Provide Covered Services. Whenever the Department determines that CCP has failed to provide one or more of the medically necessary Medicaid covered contract services required under Article IV, Service Coverage, the Department may either order CCP to provide such service, or withhold a portion of CCP's capitation payments for the following month or subsequent months, such portion withheld to be equal to the amount of money the Department must pay to provide such services. CCP shall be given at least a seven (7) day prior written notice prior regarding either (1) the Department's ordering CCP to pay, or (2) the Department's withholding any capitation payments. In case of an emergency, no such seven (7) day notice is required.

   Whenever the Department withholds payments under this section, the Department must submit to CCP a list of the participants for whom payments are being withheld, the nature of the service(s) denied, and payments the Department must make to provide medically necessary services.

2. Failure to Perform. Whenever the Department determines that CCP has failed to perform an administrative function required under this contract, the Department may withhold a portion of future capitation payments to compensate for the damages which this failure has entailed. For the purposes of this section, "administrative function" is defined as any contract obligation other than the actual provision of contract services.

3. Recovery of Damages. In any case under this contract where the Department has the authority to withhold capitation payments, the Department also has the authority to use all other legal processes for the recovery of damages.

4. Procedures. In any case where the Department intends to withhold capitation payments under section (1) above, or recover damages through the exercise of other legal processes under sections (2) or (3) above, the following procedures shall be used:

   a. The Department will notify CCP of its failure to perform a required administrative function under this contract;

b. The Department shall give CCP thirty (30) days prior notice to develop an acceptable plan for correcting this failure; and
c. If CCP has not submitted an acceptable corrective action plan within thirty (30) days, or has not implemented this plan in accordance with its terms, the Department will provide CCP with a statement itemizing the damage costs for which it intends to require compensation. The Department shall then proceed to recover said compensation.

F. Medicaid Program – Department-Initiated Disenrollment

The Department may reduce the maximum enrollment level and/or number of current enrollees whenever it determines that CCP has failed to provide one or more of the contract services required under Article IV, Service Coverage, or that CCP has failed to maintain or make available any records or reports required under this contract which the Department needs to determine whether CCP is providing contract services as required under Article IV, Service Coverage. CCP shall be given at least thirty (30) days notice prior to the Department taking any action set forth in this paragraph.

G. Medicaid Program – Sanctions

Section 1903(m)(5)(B)(ii) of the Social Security Act vests the Secretary of the DHHS with the authority to deny Medicaid payments to CCP for enrollees who enroll after the date on which CCP has been found to have committed one of the violations identified in the Federal law. State payments for enrollees of the contracting organization are automatically denied whenever, and for so long as, Federal payment for such enrollees has been denied as a result of the commission of such violations.

H. Medicaid Program – Sanctions and Remedial Actions

The Department may pursue all sanctions and remedial actions with CCP that are taken with Medicaid FFS providers, including any civil penalties not to exceed the amounts specified in the Balanced Budget Amendment of 1997, s. 4707(a).

## ARTICLE XVII

## TERMINATION AND MODIFICATION OF CONTRACT

*Contents:*



A. Outcome

The Department and CCP clearly convey the conditions and procedures for contract termination and/or modification.

This outcome is met when the Department and CCP agree to the specifications of this article as evidenced by their signatures on this contract.

B. Medicaid Program – Mutual Consent

This contract may be terminated at any time by mutual consent of both CCP and the Department.

C. Medicaid Program – Unilateral Termination

This contract may be terminated only as follows:

1. Legislative Changes. In the provision of services under this agreement, CCP and its subcontractors shall comply with all applicable Federal and State statutes and regulations, and all amendments thereto, that are in effect when the agreement is signed, or that come into effect during the term of the agreement. This includes, but is not limited to Title XIX of the Social Security Act and Title 42 of the Code of Federal Regulations. This contract may be terminated at any time, by either party, due to modifications mandated in Federal or State law, regulations, or policies that materially affect either party's rights or responsibilities under this contract. In such case, the party initiating such termination procedures must notify the other party, at least ninety (90) days prior to the proposed date of termination, of its intent to terminate this contract. Termination by the Department under these circumstances shall impose an obligation upon the Department to pay CCP's reasonable and necessarily incurred termination expenses.

2. Failure to Perform. Failure to comply and/or perform is a reason for contract termination:

a. Either party may terminate this contract at any time if it determines that the other party has substantially failed to perform any of its functions or duties under this contract. In such event, the party exercising this option must notify the other party, in writing, of this intent to terminate this contract and give the other party thirty (30) days to correct the identified violation, breach or non-performance of contract. If such violation, breach or non-performance of contract is not satisfactorily addressed within this time period, the exercising party may terminate this contract. The termination date shall always be the last day of a month. The contract may be terminated by the Department sooner than the time period specified in this paragraph if the Department finds that the participant's or participants', health or welfare is jeopardized by continued enrollment in CCP. A "substantial failure to perform" means any violation of any contractual requirement that is repeated or on-going, that goes to the essentials or purpose of this contract, or that injures, jeopardizes or threatens the health, safety, welfare, rights or other interests of recipients.

b. In lieu of termination, the Department may also impose "Temporary Management" (See Article XVI).

3. Permanent Loss of Funding. This contract may be terminated by either party, in the event that Federal or State funding of contractual services becomes permanently unavailable. In the event it becomes evident that State or Federal funding of claims payments or contractual services rendered by CCP will be temporarily suspended or unavailable, the Department shall immediately notify CCP, in writing, identifying the basis for the anticipated unavailability or suspension of funding. Upon such notice, the Department or CCP may suspend performance of any or all of CCP's obligations under this contract if the suspension or unavailability of funding will preclude reimbursement for performance of those obligations. The Department or CCP shall attempt to give notice of suspension of performance of any or all of CCP's obligations by sixty (60) calendar days prior to said suspension, if this is possible; otherwise, such notice of suspension should be made as soon as possible.

4. Temporary Loss of Funding. In the event funding is reinstated, CCP may remove suspension hereunder by written notice to the Department, within thirty (30) calendar days from the date of reinstatement of funds. In the event CCP elects not to reinstate services, CCP shall give the Department written notice of its reasons for such decision, to be made within thirty (30) calendar days from the date the funds are reinstated. CCP shall make such decision in good faith and will provide to the Department documentation supporting this decision. In the event of termination under this Section, this contract shall terminate without termination costs to either party.

D. Medicaid Program – Obligations of Contracting Parties

When termination of the contract occurs, the following obligations shall be met by the parties:

1. Where this contract is terminated unilaterally by the Department, due to non-performance by CCP or by mutual consent with termination initiated by CCP:

a. The Department shall be responsible for notifying all enrollees of the date of termination and process by which the enrollees will continue to receive contract services; and
b. CCP shall be responsible for all expenses related to said notification.

2. Where this contract is terminated on any basis not given in (1) above:

a. The Department shall be responsible for notifying all enrollees on the date of termination and process by which the enrollees will continue to receive contract services; and
b. The Department shall be responsible for all expenses relating to said notification.

3. Where this contract is terminated for any reason:

a. Any payments advanced to CCP for coverage of enrollees for periods after the date of termination shall be promptly returned to the Department; and
b. CCP shall promptly supply all information necessary for the reimbursement of any outstanding Medicaid claims.
c. If a contract is terminated, recoupments will be handled through a payment by CCP within ninety (90) days of contract termination.

4. Where this contract is terminated for any reason, CCP shall assist participants in their transition to FFS.

E. Medicaid Program – Modification

This contract may be modified at any time by written mutual consent of CCP and the Department or when modifications are mandated by changes in Federal or State laws, rules or regulations. In the event that changes in State or Federal law, rules or regulations require the Department to modify its contract with CCP, notice shall be made to CCP in writing. However, the capitation rate to CCP can be modified only as provided in Article XIII, Payment to CCP, relating to RENEGOTIATION.

Enrollment limits may be modified at any time by written mutual consent of CCP and the Department. The Department may, by written mutual consent with CCP and other interested parties, redistribute available enrollment months to facilitate continuity of services for program members.

If the Department offers to renew this contract, as allowed by Article XIII, Payments to CCP, the Department will recalculate the capitation rate for succeeding calendar years. The Department and CCP will then have thirty (30) days to negotiate the new capitation rate in writing or to initiate termination of the contract.

## ARTICLE XVIII

## INTERPRETATION OF CONTRACT LANGUAGE

*Contents:*



A. Outcome

The Department will provide clear interpretation of contract language and provide an avenue for appeal of interpretations.

B. Interpretations and Appeals

The Department has the right to interpret the contract language when disputes arise. CCP has the right to appeal to the Department or to invoke the procedures outlined in Chapter 788, Arbitration or Chapter 227 Wis. Stats., if it disagrees with the Department's interpretation. Until a decision is reached, CCP shall abide by the interpretation of the Department.

C. Documents Constituting Contract

The contractual agreement between the parties to this contract shall include, in addition to this document, existing Medicaid Provider Bulletins addressed to managed care organizations (MCO's). In the event of any conflict in provisions among these documents, the terms of this contract shall prevail. In addition, the contract shall incorporate the following Addenda:

1. Protocol for Partnership.

2. Adverse Action Dates

3. Policy Guidelines on Community –Based Programs

4. CMS Guidelines for Access Standards

5. Reporting Requirements

6. COB Report Format

7. Actuarial Basis

8. Compliance Agreement: Affirmative Action/Civil Rights

9. Personal Injury Settlements

10. Payment Schedule

11. Performance Improvement Project Outline

12. AIDS/Ventilator Dependent Report Format

D. Future Documents

This contract requires CCP to comply with all future Medicaid Provider Publications addressed to the MCO's and Partnership Contract Interpretation Bulletins and Policy Memos issued pursuant to this contract.

The documents listed above constitute the entire contract between the parties and no other expression, whether oral or written, constitutes any part of this contract.

E. Indemnification

1. CCP agrees to defend, indemnify and hold the Department harmless, with respect to any and all claims, costs, damages and expenses, including reasonable attorney's fees, which are related to or arise out of:

    a. Any failure, inability, or refusal of CCP or any of its subcontractors to provide contract services;
    b. The negligent provision of contract services by CCP or any of its subcontractors; or
    c. Any failure, inability or refusal of CCP to pay any of its subcontractors for contract services.

2. The Department agrees to be responsible to CCP (and its officers, directors, employees, agents, and subcontractors), for any and all liability, loss, damage, cost, or expense which arises out of any negligent act or omission of the Department or any of its officers, agents or employees while acting within the scope of their employment, where protection is afforded by s. 893.82 and 895.46(1) of the Wisconsin statutes.

F. Independent Capacity of Contractor

The Department and CCP agree that CCP and any agents or employees of CCP, in the performance of this contract, shall act in an independent capacity, and not as officers or employees of the Department.

G. Omissions

In the event that either party hereto discovers any material omission in the provisions of this contract which such party believes is essential to the successful performance of this contract, said party may so inform the other party in writing, and the parties hereto shall thereafter promptly negotiate in good faith with respect to such matters for the purpose of making such reasonable adjustments as may be necessary to perform the objectives of this contract.

H. Choice of Law

This contract shall be governed by and construed in accordance with the laws of the State of Wisconsin. CCP shall be required to bring all legal proceedings against Department in Wisconsin State courts.

I. Waiver

No delay or failure by either party hereto to exercise any right or power accruing upon noncompliance or default by the other party with respect to any of the terms of this contract shall impair such right or power or be construed to be a waiver thereof. A waiver by either of the parties hereto of a breach of any of the covenants, conditions, or agreements to be performed by the other shall not be construed to be a waiver of any succeeding breach thereof or of any other covenant, condition, or agreement herein contained.

J. Severability – Medicaid

If any provision of this contract is declared or found to be illegal, unenforceable, invalid or void, then both parties shall be relieved of all obligations arising under such provision; but if such provision does not relate to payments or services to Medicaid enrollees and if the remainder of this contract shall not be affected by such declaration or finding, then each provision not so affected shall be enforced to the fullest extent permitted by law.

K. Force Majeure

Both parties shall be excused from performance hereunder for any period that they are prevented from meeting the terms of this contract as a result of a catastrophic occurrence or natural disaster including but not limited to an act of war, and excluding labor disputes.

L. Headings

The article and section headings used herein are for reference and convenience only and shall not entire into the interpretation hereof.

M. Assignability

Except as allowed under subcontracting, the contract is not assignable by CCP either in whole or in part, without the prior written consent of the Department.

N. Survival

The terms and conditions contained in this contract that by their sense and context are intended to survive the performance by the parties shall so survive the completion of the performance, expiration or termination of the contract.

## ARTICLE XIX
## CONTRACT FOR MEDICAID SERVICES

### COMMUNITY CARE PARTNERSHIP, INC. SPECIFIC CONTRACT TERMS

**1. COUNTY WHERE ENROLLMENT IS ACCEPTED:**

Mississippi County

**2. MAXIMUM ENROLLMENT LEVEL:**

There is no census maximum under this contract.

The Department does not guarantee any minimum enrollment level.

**3. CAPITATION RATE:**

This is the monthly capitation rate for each non-ISN enrollee:

| | |
|---|---|
| Elderly - Mississippi County | $ |
| Disabled - Mississippi County | $ |

**4. ISN CAPITATION RATE:**

This is the monthly capitation rate for ISN qualified members:

| | |
|---|---|
| Elderly - Mississippi Count | $ |
| Disabled - Mississippi County | $ |

**5. COVERAGE OF DENTAL:** YES

**THIS CONTRACT SHALL BECOME EFFECTIVE ON January 1, 2004, AND SHALL TERMINATE ON DECEMBER 31, 2004**

In WITNESS WHEREOF, the State of Wisconsin and Community Care Partnership, Inc., have executed this agreement:

| **Community Care Partnership, Inc.** | **Department of Health and Family Services** |
|---|---|
| Signature | Sinikka Santala |
| Title | Title<br>Administrator<br>Division of Disability and Elder Services |
| Date | Date |

## ADDENDUM I

## Adverse Action Dates

The Adverse Action dates for 2004 are:

1/16
2/16
3/18
4/16
5/18
6/17
7/16
8/18
9/16
10/18
11/17
12/16

## ADDENDUM II

## POLICY GUIDELINES ON COMMUNITY-BASED PROGRAMS

CCP shall develop a working relationship with community agencies which are involved in the provision of non-medical services to enrollees. CCP may under certain conditions be exempted from taking on or continuing to service Medicaid CCP members who require highly specialized or extensive treatment and/or non-medical services for mental illness, methadone treatment, developmental disabilities, or due to elder abuse or domestic violence. The extent of CCP responsibility for working cooperatively with other community agencies, for treating the medical aspects of the above conditions as legitimate health care problems and the terms under which enrollee exemption may be obtained are specified as follows:

A. Mental Health/AODA Assessment Requirements

CCP shall further assure that authorization for MH/AODA treatment to its enrollees shall be governed by the findings of an assessment performed promptly by CCP upon request of a client or referral from a physician. Such assessments shall be conducted by qualified staff in certified programs, who are experienced in MH/AODA. All denials of service and the selection of particular modalities of service shall be governed by the findings of this assessment and the medical necessity of treatment. The lack of motivation of a member to participate in treatment shall not be considered a factor in determining medical necessity and may not be used as a rationale for withholding or limiting treatment of a member.

CCP shall involve and engage the member in the process used to select a provider and treatment option. The purpose of the participation is to get a good match between the member's condition, cultural preference (See Article V, Provider Network), medical needs and the provider who will seek to meet these needs. This section does not require CCP to use providers who are not qualified to treat the individual enrollee or who are not contracted providers.

B. Assurance of Expertise for Elder Abuse, Abuse of Vulnerable Adults, and Domestic Violence

CCP shall arrange for the provision of examination and treatment services by providers with expertise and experience in dealing with the medical/psychiatric aspects of caring for victims and perpetrators of elder abuse, abuse of vulnerable adults, and domestic violence. Such expertise shall include the identification of possible and potential victims of elder abuse and domestic violence, statutory reporting requirements, and local community resources for the prevention and treatment of elder abuse and domestic violence. CCP shall consult with human service agencies on appropriate providers in their community.

CCP shall further assure that providers with appropriate expertise and experience in dealing with perpetrators and victims of domestic abuse and incest are utilized in service provision.

C. Court-Related AODA Services

Necessary CCP referrals or treatment authorized for court-related AODA services must be furnished promptly. It is expected that no more than five (5) days will elapse between receipt of a written request by CCP and the issuance of a referral or authorization for treatment. Such referral or authorization, once determined to be medically necessary, will be retroactive to the date of the request. After the fifth day an assumption will exist that an authorization has been made until such time as CCP responds in writing.

E. Dispute Resolution

The Department shall be the sole arbitrator of disputes and all requirements of this addendum.

1. Request for Department's Review. A local board, county social or human service department, recipient, or advocate for a recipient, may request a review of complaints regarding denial of access to medically necessary MA-covered services after they have utilized CCP dispute resolution process. The Department shall review the complaint and make a final determination. The Department will accept written comments from all parties to the dispute prior to making a decision. Failure to promptly (within forty-five (45) days) pay providers for properly referred care will be considered as a denial of access to such care.

2. Department's Ruling. Where a Departmental ruling is invoked in any dispute relating to the terms of this addendum, the Department's decision shall be communicated to CCP and all other appropriate individuals or organizations in writing and within thirty (30) days of receipt of the request. CCP shall abide by all decisions of the Department.

## ADDENDUM III

## CMS GUIDELINES FOR ACCESS STANDARDS

CMS has issued the following Access Standards.

A. Policy

Contractors shall provide available, accessible, and adequate numbers of institutional facilities, service locations, service sites, professional, allied, and paramedical personnel for the provision of all covered services on an emergency basis, twenty-four (24) hour–a-day, and seven-day-a-week basis. The Department is invited to propose specific access measures designed for frail elderly and for beneficiaries with physical disabilities, however, at a minimum, shall include:

B. Procedures

1. Time/Distance.

a. Time/Distance to Primary Care and Hospitals. The Department shall demonstrate that provider networks are in place which guarantee all clients in urban or suburban locations access to primary care sites and hospitals within thirty (30) minutes or twenty (20) miles of their residence. Transport time and distance in rural areas to primary care sites and hospital may be greater than thirty (30) minutes or twenty (20) miles if based on the community standard for accessing care. Where greater, the exceptions must be justified and documented on the basis of community standards. This information must be made available for review upon CMS's request.

b. Time/Distance to Specialty Care Locations. Travel time/distances to all types of specialty care, including mental health, pharmacy, general optometry, lab and x-ray services, and long-term care services shall not exceed thirty (30) minutes or thirty (30) miles from the member's residence. The Department may exempt individuals who request to receive services from a specialty provider with whom they have an established relationship but the travel time or distance is greater than thirty (30) minutes or thirty (30) miles.

2. Appointment Times. Partnership organizations shall employ sufficient medical personnel and staff to be able to meet basic standards in the scheduling of appointments for their participants or members. Appointments must be available for eligible recipients in accordance with the usual and customary practice standards and hours of operation. Maximum expected waiting times shall be as follows:

a. Emergency Care. Emergency care must be provided as the situation dictates. In general, emergency care must be given in accordance to the time frame

dictated by the nature of the emergency, at the nearest available facility, twenty-four hours a day, seven days a week, regardless of contracts.

b. Urgent Care. Triage and appropriate treatment shall be provided on the same or next day.
c. Non-Urgent Problems and Routine Primary Care. Appointments for non-urgent care and routine primary care shall be provided within three weeks of client request.
d. Specialty Care. Referral appointments to specialists, except for specialists providing mental health and substance abuse services (e.g., specialty physician services, hospice care, home health care, and certain rehabilitation services, etc.) shall not exceed thirty (30) days for routine care or forty eight (48) hours for urgent care. All emergency care must be provided on an immediate basis, at the nearest facility available, regardless of contracting arrangements.
e. General Optometry Services. Partnership organizations must have a system in place to document compliance with the following appointment scheduling time frames. The Department shall monitor compliance with appointment/waiting time standards as part of the required surveys and monitoring requirements.
f. Transport Time. Transport time will be the usual and customary, not to exceed one hour, except in areas where community access standards and documentation will apply.
g. Appointment/Waiting Times. Usual and customary not to exceed thirty (30) days for regular appointments and forty-eight (48) hours for urgent care. (Note: "Usual and customary" means access that is equal to or greater than the currently existing practice in the FFS system.)
h. Pharmacy Services. Partnership organizations must have a system in place to document compliance with the following appointment scheduling time frames. The Department shall monitor compliance with appointment/waiting time standards as part of the required surveys and monitoring requirements.
i. Lab and X-Ray Services. Partnership organizations must have a system in place to document compliance with the following appointment scheduling time frames. The Department shall monitor compliance with appointment/waiting time standards as part of the required surveys and monitoring requirements.

3. In-Office Waiting Times. Partnership members with an appointment shall not routinely be made to wait longer than one hour.

4. Patient Load. The Department shall determine the ratio of Partnership members to primary care physicians. (CMS project officer shall approve patient load ratio, thirty (30) days prior to implementation of the program.

5. Documentation/Tracking Requirements.

a. Documentation. Partnership organizations must have a system in place to document appointment scheduling times. Wisconsin must utilize statistically valid sampling methods for monitoring compliance with appointment/waiting time standards as part of the required beneficiary survey and reported to the Department on an annual basis.
b. Tracking. Partnership organizations must have a system in place to document the exchange of client information with the primary care provider if a school-based health center, not serving as the primary care provider, provides health care.

6. Corrective Action Plan. CMS requires the Department to have a corrective action plan for Partnership organizations that score less than 70 percent (or below the benchmarks established by the Department) in beneficiary satisfaction. The Department will monitor the plan.

## Addendum IV

## STATE REPORTING REQUIREMENTS FOR 2004

| Due Date | Type of Report | Reporting Period | Send Report to… | Report Format | Reporting Frequency | Contract Reference(s) |
|---|---|---|---|---|---|---|
| Before contract signing | Affidavit: Standard Language in Subcontracts | | CDSD | Hardcopy | Required Annually | Art V, B, 2,a Protocol, pg. 18 |
| Within 15 days contract signing | Civil Rights Compliance Plan with Work Force Analysis. | Contract Period | AA/CR | Hardcopy | Required Triannually | Art XI, A, 1 Add VII,C, 1 |
| Within 30 days of contract signing | Disclosure of Interest | Prior Twelve Months | CDSD | Hardcopy | Required Annually | Art III, C, 2 |
| YEAR 2004 | | | | | | |
| **FIRST QUARTER** | | | | | | |
| January 31 | QA/QI Plan for 2004 | Contract Period | CDSD | Hardcopy | Required Annually | Art X, A, 1, a Art X, C |
| January 31 | 2003 Annual Performance Improvement Projects | Contract Period | CDSD | Hardcopy | Required Annually | Art X, J, 2 Add X |
| January 31 | ISN Cases | July 1, 2003 through Dec. 31, 2003 | CDSD | Hardcopy | Required Semiannually | Article XIII, C, 5 |
| February 1 | Mini-Encounter Data File | Jan. 1, 2003 thru Dec. 31, 2003 | EDS | Electronic Media (including email) | Required Quarterly | Art. X, D, 1 Utilization Reporting User Manual pg. 24 |
| February 1 | Intake, Enrollment and Event Data File | Jan. 1, 2003 thru Dec. 31, 2003 | EDS | Electronic Media (including email) | Required Semiannually | Art. X, D, 1 Utilization Reporting User Manual pg. 7 |
| February 1 | Complaints and Appeals Summary Report | Oct 1, 2003 through Dec 31, 2003 | CDSD | Email or Hardcopy | Required Quarterly | Art IX, A, 3 and M |
| February 1 | AIDS/ Ventilator Dependent Report | Reportable Costs as of Present Time | EDS - Olin | Hardcopy and Diskette | Ad-Hoc Quarterly | Art XIII, I Add XI |
| February 15 | Provider Network Listing and Physician Credentialing Review | As of Present Time | CDSD | Hardcopy | Required Annually | Art. V, B, 1, b Art X, A, 1, d Art X, F, 2 |
| February 15 | Semiannual Progress Report | Jul 1, 2003 through Dec 31, 2003 | CDSD | Hardcopy | Required Semiannually | Art X, J, 5 |
| February 15 | Financial Report | Oct 1, 2003 through Dec 31, 2003 | CDSD | Hardcopy | Required Quarterly | Art XIV,B, 7 Protocol, pg. 150 |
| February 15 | Coordination of Benefits Report | Oct 1, 2003 through Dec 31, 2003 | CDSD | Hardcopy | Required Quarterly | Art XIII, F, 3 Add V |
| February 15 | Federally Qualified Health Centers Report | Oct 1, 2003 through Dec 31, 2003 | CDSD | Hardcopy | Ad-Hoc Quarterly | Art V, N |
| **SECOND QUARTER** | | | | | | |
| May 1 | Complaints and Appeals Summary Report | Jan 1, 2004 through Mar 31, 2004 | CDSD | Email or Hardcopy | Required Quarterly | see above |

| | | | | | | |
|---|---|---|---|---|---|---|
| May 1 | Mini-Encounter Data File | Jan 1, 2004 thru March 31, 2004 | EDS - MEDS | Electronic Media (including email) | Required Quarterly | see above |
| May 1 | AIDS/ Ventilator Dependent Report | Reportable Costs as of Present Time | EDS - Olin | Hardcopy and Diskette | Ad-Hoc Quarterly | see above |
| **Due Date** | **Type of Report** | **Reporting Period** | **Send Report to…** | | **Reporting Frequency** | **Contract Reference(s)** |
| May 15 | Financial Report | Jan 1, 2004 through Mar 31, 2004 | CDSD | Hardcopy | Required Quarterly | see above |
| May 15 | Coordination of Benefits Report | Jan 1,2004 through Mar 31, 2004 | CDSD | Hardcopy | Required Quarterly | see above |
| May 15 | Federally Qualified Health Centers Report | Jan 1, 2004 through Mar 31, 2004 | CDSD | Hardcopy | Ad-Hoc Quarterly | see above |
| June 30 | OCI Report | Jan 1, 2003 through Dec 31, 2003 | CDSD | Hardcopy | Annual | Art. III.B. |
| **THIRD QUARTER** | | | | | | |
| July 1 | Annual Fiscal Audit | Jan 1, 2003 through Dec 31, 2003 | CDSD | Hardcopy | Required Annually | Art XIV, B, 9 Protocol pg. 151 |
| July 30 | ISN Cases | Jan 1, 2004 through June 30, 2004 | CDSD | Hardcopy | Required Semiannually | Article XIII, C, 5 |
| August 1 | Complaints and Appeals Summary Report | Apr 1, 2004 through Jun 30, 2004 | CDSD | Email or Hardcopy | Required Quarterly | see above |
| August 1 | Mini-Encounter Data File | Jan 1, 2004 thru June 30, 2004 | EDS - MEDS | Electronic Media (including email) | Required Quarterly | see above |
| August 11 | Intake, Enrollment and Event Data File | Jan. 1, 2004 through June 30, 2004 | EDS | Electronic Media (including email) | Required Semiannually | see above |
| August 1 | AIDS/ Ventilator Dependent Report | Reportable Costs as of Present Time | EDS - Olin | Hardcopy and Diskette | Ad-Hoc Quarterly | see above |
| August 15 | Semiannual Narrative Report | Jan 1, 2004 through Jun 30, 2004 | CDSD | Hardcopy | Required Semiannually | see above |
| August 15 | Financial Report | Apr 1, 2004 through Jun 30, 2004 | CDSD | Hardcopy | Required Quarterly | see above |
| August 15 | Coordination of Benefits Report | Apr 1, 2004 through Jun 30, 2004 | CDSD | Hardcopy | Required Quarterly | see above |
| August 15 | Federally Qualified Health Centers Report | Apr 1, 2004 through Jun 30, 2004 | CDSD | Hardcopy | Ad-Hoc Quarterly | see above |
| **FOURTH QUARTER** | | | | | | |
| November 1 | Complaints and Appeals Summary Report | Jul 1, 2004 through Sep 30, 2004 | CDSD | Email or Hardcopy | Required Quarterly | see above |

| | | | | | | |
|---|---|---|---|---|---|---|
| November 1 | Mini-Encounter Data File | Jan 1, 2004 thru Sept. 30, 2004 | EDS - MEDS | Electronic Media (including email) | Required Quarterly | see above |
| November 1 | AIDS/ Ventilator Dependent Report | Reportable Costs as of Present Time | EDS - Olin | Hardcopy and Diskette | Ad-Hoc Quarterly | see above |
| November 15 | Financial Report | Jul 1, 2004 through Sep 30, 2004 | CDSD | Hardcopy | Required Quarterly | see above |
| November 15 | Coordination of Benefits Report | Jul 1, 2004 through Sep 30, 2004 | CDSD | Hardcopy | Required Quarterly | see above |
| **Due Date** | **Type of Report** | **Reporting Period** | **Send Report to…** | | **Reporting Frequency** | **Contract Reference(s)** |
| November 15 | Federally Qualified Health Centers Report | Jul 1, 2004 through Sep 30, 2004 | CDSD | Hardcopy | Ad-Hoc Quarterly | see above |
| December 1 | Delegation of Authority | Contract Period | CDSD | Hardcopy | Required Annually | Art II, A, 1, c, (1)<br>Art X, A, 1, b |
| December 1 | Satisfaction Survey | Contract Period | CDSD | Hardcopy | Required Annually | Art X, J, 1<br>Add III, B, 5, a |
| YEAR 2005 | | | | | | |
| **FIRST QUARTER** | | | | | | |
| January 31 | ISN Cases | July 1, 2004 through December 31, 2004 | CDSD | Hardcopy | Required Semiannually | see above |
| January 31 | QA/QI Plan for 2005 | Contract Period | CDSD | Hardcopy | Required Annually | see above |
| January 31 | 2004 Annual Performance Improvement Projects | Contract Period | CDSD | Hardcopy | Required Annually | see above |
| February 1 | Complaints and Appeals Summary Report | Oct 1, 2004 through Dec 31, 2004 | CDSD | Email or Hardcopy | Required Quarterly | see above |
| February 1 | Mini-Encounter Data File | Jan 1, 2004 thru Dec. 31, 2004 | EDS - MEDS | Electronic Media (including email) | Required Quarterly | see above |
| February 1 | Intake, Enrollment and Event Data File | Jan. 1, 2004 through Dec. 31, 2004 | EDS | Electronic Media (including email) | Required Semiannually | see above |
| February 1 | AIDS/ Ventilator Dependent Report | Reportable Costs as of Present Time | EDS - Olin | Hardcopy and Diskette | Ad-Hoc Quarterly | see above |
| February 15 | Provider Network Listing | As of Present Time | CDSD | Hardcopy | Required Annually | see above |
| February 15 | Semiannual Narrative Report | Jul 1, 2004 through Dec 31, 2004 | CDSD | Hardcopy | Required Semiannually | see above |
| February 15 | Financial Report | Oct 1, 2004 through Dec 31, 2004 | CDSD | Hardcopy | Required Quarterly | see above |
| February 15 | Coordination of Benefits Report | Oct 1, 2004 through Dec 31, 2004 | CDSD | Hardcopy | Required Quarterly | see above |
| February 15 | Federally Qualified Health Centers Report | Oct 1, 2004 through Dec 31, 2004 | CDSD | Hardcopy | Ad-Hoc Quarterly | see above |

Reports With No Due Date

| Due Date | Type of Report | Contract Reference(s) |
|---|---|---|
| As requested by the Department | Subcontracts – template versus individuals | Article V, B, 1 |
| When applicable | Business Transactions – Party-In-Interest Disclosure | Article III, C, 3 |
| When applicable | List of physicians terminated because of quality issues | Article X, F, 4 |
| When applicable | Personal injury settlements | Article XIII, F, 5<br>Addendum VIII |
| When actual enrollment varies significantly from the Department's target | Target Member Month Variations | Article VII, C, 3 |
| 45 days after risk reserve disbursement | Risk reserve disbursement and replenishment plan<br>Note: depository organization will submit annual reports to the Department on status of risk reserve account | Article XIV, B, 6 |
| When applicable | If EC implements physician incentive plan, provide CMS and the Department info to determine whether plan is in compliance | Protocol, pg. 36 |
| When applicable | Abortions & hysterectomies/sterilizations | Article IV, C, 1 |
| Upon request | HMO licensure reports and/or correspondence | Article XIV, B, 1 |
| 45 days before planned distribution | Participant Handbook | Article VI, E, 1<br>Protocol, pg. 42 |
| 45 days before planned distribution | Marketing Materials | Article VI, B<br>Protocol, pg. 37 |
| Available upon request | Interpreter services | Article VIII, D, 2 |
| Upon request | Nursing Home Relocations | Article VII, C, 4 |
| Within 60 days of External Review's identification of adverse health situation | Corrective action plan | Protocol, pg. 115 |

CCP shall submit reports required under this contract, by the due dates indicated above, to:

**AA/CR**
Department of Health and Family Services
Affirmative Action/Civil Rights Compliance Office
P.O. Box 7850
Madison, WI 53707-7850

**CDSD**
Department of Health and Family Services
Division of Disability and Elder Services
Center for Delivery Systems Development
1 West Wilson, Rm. 518
PO Box 7851
Madison, WI 53707-7851

**EDS - MEDS**
EDS - MEDS
10 East Doty Street, Suite 200
Madison, WI 53703

**EDS - Olin**

EDS
Attn: Managed Care
P.O. Box 6470
Madison, WI 53716-0470

**ADDENDUM V**

**COB REPORT FORMAT**

Name of Partnership Organization _____

Mailing Address _____

Office Telephone _____ _____

Provider Number _____ _____

Please designate below the quarter period for which information is given in this report.

_____, 20____ through _____, 20_____

INSTRUCTIONS

For the purposes of this report, an enrollee is any Medicaid recipient listed on the monthly enrollment reports coming from the fiscal agent, and who is an ADD or CONTINUE.

Subrogation may include collections from auto, homeowners, or malpractice insurance, as well as restitution payments from the Division of Corrections. In addition, subrogation should include collections from Workers' Compensation.

Birth costs are not a third party right, and consequently are not included in this report.

Coordination of Benefits Reports are to be completed on a calendar quarterly basis.

The report is to be aggregated for all separate service areas if CCP has more than one service area.

Please complete and return this report within forty-five (45) days of the end of the quarter being reported to:

Department of Health and Family Services
Division of Disability and Elder Services
Center for Delivery Systems Development
1 West Wilson, Rm. 518
PO Box 7851
Madison, WI 53707-7851

Attn: COB Report from _____CCP

## COB REPORT

The following information is **REQUIRED** in order to comply with CMS reporting requirements:

Cost Avoidance

Indicate the dollar amount of the claims you denied as a result of your knowledge of other insurance being available for the enrollee. The provider did not indicate at the time of the claim submission (with an EOB, etc.) that the other insurance was billed prior to submitting the claim to you. Therefore, you denied the claim. Please indicate the dollar amount of these denials.

Dollar Amount Cost Avoided: _____

**Recoveries (Post-Pay Billing/Pay and Chase)**

Indicate the dollar amount you received as a result of billing an enrollee's other insurance.

Dollar Amount Collected From Other Insurance: _____

Subrogation/Worker's Compensation
Recoveries (Dollars) This Quarter: _____

I HEREBY CERTIFY that to the best of my knowledge and belief, the information contained in this report is a correct and complete statement prepared from the records of CCP, except as noted on the report.

Signed: _____
Original Signature of Director or Administrator

Title: _____

Date Signed: _____

## ADDENDUM VI

## ACTUARIAL BASIS

The actuarial basis for the contract year 2004 capitation rates for CCP was developed by the Department with assistance from Milliman, Inc., Actuaries and Consultants.

The SNF/ICF capitation rate for CCP has been calculated to cover nursing facility, physician, and all other mandatory and optional services.

### Elderly

| | NH Residents | NH Eligible in Community |
|---|---|---|
| 1 Mississippi County projected NH PMPM or Waiver Services plus Projected fee for service costs PMPM | | |
| 2 PMPM Plus Drug rebate | | |
| 3 Plus: Administrative costs four-point-four-one (4.41) percent | | |
| 4 SNF/ICF PMPM Component for CY 2004 | | |
| 5 Less: five (5) percent managed care discount | | |
| 6 Eligible County Months by Eligibility Group | | |
| 7 Weight of NH resident vs. community based component | | |
| 8 SNF/ICF Capitation rate for CY 2004 | | |

The ISN capitation rate for CCP has been calculated to cover nursing facility, physician, and all other mandatory and optional services.

| |
|---|
| 1 Mississippi County projected NH PMPM or Waiver Services plus Projected fee for service costs PMPM |
| 2 Less: Drug rebate |
| 3 Plus: Administrative costs four-point-four-one (4.41) percent |
| 4 Less: five (5) percent managed care discount |
| 5 ISN Capitation rate for CY 2004 |

**Physical Disabilities**

| | NH Residents | NH Eligible in Community |
|---|---|---|
| 1 Mississippi County County projected NH PMPM or Waiver Services plus Projected fee for service costs PMPM | | |
| 2 PMPM Plus Drug rebate | | |
| 3 Plus: Administrative costs four-point-four-one (4.41) percent | | |
| 4 SNF/ICF PMPM Component for CY 2004 | | |
| 5 Less: five (5) percent managed care discount | | |
| 6 Eligible County Months by Eligibility Group | | |
| 7 Weight of NH resident vs. community based component | | |
| 8 SNF/ICF Capitation rate for CY 2004 | | |

The ISN capitation rate for CCP has been calculated to cover nursing facility, physician, and all other mandatory and optional services.

| |
|---|
| 1 Mississippi County projected NH PMPM or Waiver Services plus Projected fee for service costs PMPM |
| 2 Less: Drug rebate |
| 3 Plus: Administrative costs four-point-four-one (4.41) percent |
| 4 Less: five (5) percent managed care discount |
| 5 ISN Capitation rate for CY 2004 |

## ADDENDUM VII

## COMPLIANCE AGREEMENT AFFIRMATIVE ACTION/CIVIL RIGHTS

COMMUNITY CARE PARTNERSHIP HEREBY AGREES THAT it will comply with the following:[2]

A. CCP shall implement and adhere to rules and regulations prescribed by the United States, Department of Labor and in accordance with 41 Code of Federal Regulations, Chapter 60.

B. CCP shall comply with regulations of the United States Department of Labor recited in 20 Code of Federal Regulations, Part 741 and the Federal Rehabilitation Act of 1973. CCP shall ensure compliance by any and all subcontractors engaged by Contractor under the Contract with said regulations.

C. Civil Rights Compliance Plans with Work Force Analysis.

1. CCP assures that they have submitted to the Department Affirmative Action/Civil Rights Compliance Office a current copy of a Civil Rights Compliance Action Plan for Meeting Equal Opportunity Requirements under Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title VI and XVI of the Public Service Health Act, the Age Discrimination Act of 1975, the Omnibus Budget Reconciliation Act of 1981, the Americans with Disabilities Act (ADA) of 1990, the Federal Limited English Proficiency (LEP) Guidelines of August 2000, the Wisconsin Fair Employment Act, and any or all applicable Federal and State nondiscrimination statutes as may be in effect during the term of this Contract. If an approved plan has been reviewed during the three year plan period, a plan update must be submitted when changes occur within the plan. The plan covers a three-year period from January 1, 2004 through December 31, 2006.

    a. No otherwise qualified person shall be excluded from participation in, be denied the benefits of, or otherwise subject to discrimination in any manner on the basis of race, color, national origin, sexual orientation, religion, sex, disability or age. This policy covers eligibility for and access to service delivery, and treatment in all programs and activities.

    b. No otherwise qualified person shall be excluded from employment, be denied the benefits of employment or otherwise be subject to discrimination in employment in any manner or term of employment on the basis of age, race, religion, color, sex, national origin, or ancestry, handicap [as defined in Section 504 and the American With Disabilities Act (ADA)], physical condition, developmental disability [as defined in s. 51.05(5) Wis. Stats.], arrest or conviction record [in keeping with s.111.32 Wis. Stats.], sexual orientation, marital status, or military participation. All employees are expected to support goals and programmatic activities relating to nondiscrimination in employment.

[2] See general contract provisions under 42 CFR 422.502(h)(1).

2. CCP shall post the Equal Opportunity Policy, the name of the Equal Opportunity/Civil Rights Compliance Coordinator and the discrimination complaint process in conspicuous places available to applicants and clients of services, and applicants for employment and employees. The complaint process will be according to Department standards and made available in languages and formats understandable to applicants, clients and employees. CCP will continue to provide appropriate translated State procedures in writing, mandated brochures, and forms for local distribution. CCP will also provide interpretation/translation services as determined by the Federal LEP Guidelines.

3. CCP agrees to comply with guidelines in the Civil Rights Compliance Standards and a Resource Manual for Equal Opportunity in Service Delivery and Employment for the Wisconsin Department of Health and Family Services, its Service Providers and their Subcontractors (Form DWSD-12046-E-P (R.01/2002, effective January 1, 2002 through December 31, 2003).

4. Requirements herein stated apply to any subcontracts. CCP has primary responsibility to take constructive steps, as per the CRC Standards and Resource Manual and other pertinent Department directives and guidelines, to ensure compliance of subcontractors. However, where the Department has a direct contract with another community agency or vendor, CCP need not obtain a Subcontractor Affirmative Action Plan and Civil Rights Compliance Action Plan or monitor that agency or vendor.

5. The Department will monitor the Civil Rights Compliance of CCP and will conduct reviews to ensure that CCP is ensuring compliance of its subcontractors in compliance with guidelines in the CRC Standards and Resource Manual. CCP agrees to comply with Civil Rights monitoring reviews, including the examination of records and relevant files maintained by CCP, as well as interviews with staff, clients, applicants for services, subcontractors and referral agencies.

6. CCP agrees to cooperate with the Department in developing, implementing and monitoring corrective action plans that result from complaint investigations or other monitoring efforts.

D. Access to Agency

1. CCP agrees to hire staff, contract with, or identify community individuals with special translation or sign language skills and/or provide staff with special translation or sign language skills training or find persons who are available within reasonable time and who can communicate with non-English speaking or hearing impaired clients; train staff in human relations techniques; develop staff competency to address the needs of persons with disabilities and cultural differences; and make programs and facilities accessible, as appropriate, through outstations, authorized representatives, adjusted work hours, ramps, doorways, elevators or ground floor rooms, and Braille, large print or taped information for the visually impaired. Informational materials will be posted and/or available in languages and formats appropriate to the needs of the client population in accordance with Federal law and guidelines.

2. CCP shall ensure the establishment of safeguards to prevent employees, consultants or members of governing bodies from using their positions for purposes that are, or give the appearance of being, motivated by a desire for private gain for themselves or others, such as those with whom they have family, business, or other ties as specified in Wis. Statutes 946.10 and 946.13.

3. The applicant gives assurance that he/she will immediately take any measures necessary to effectuate this agreement.

4. The applicant shall comply with Conflict of Interest (Section 946.10 and 946.13 Wis. Stats. and the Department Employee Guidelines DMB-Pers. 102-7/1/71).

## ADDENDUM VIII

## Community Care Partnership PERSONAL INJURY SETTLEMENTS

| Name of Recipient and MA ID Number | Date TPL Payment Received | If Available | | Payer |
|---|---|---|---|---|
| | | Attorney Name | Amt. Received | |
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |
| 11. | | | | |
| 12. | | | | |

**Mail this Form to:** Department of Health and Family Services
Division of Disability and Elder Services
Center for Delivery Systems Development
1 West Wilson, Rm. 518
PO Box 7851
Madison, WI 53707-7851

## ADDENDUM IX

### Payment Schedule
### Enrollment Cycles, Recoupments, and R&S Schedule - 2004

| Enrollment Month & Year | Initial Enrollment Cycle Reports | Final Enrollment Cycle Reports | Systematic Recoupment Cycle Run | Next Remittance and Status (R/S) Date |
|---|---|---|---|---|
| 01/04 | 12/17/03 (Wed) | | 12/18/03 (Thur) | 12/21/03 |
| | | 12/30/03 (Tue) | 01/02/04 (Fri) | 01/04/04 |
| | | | | |
| 02/04 | 01/20/04 (Tue) | | 01/21/04 (Wed) | 01/25/04 |
| | | 01/30/04 (Fri) | 02/02/04 (Mon) | 01/30/04 & 02/08/04 |
| | | | | |
| 03/04 | 02/17/04 (Tue) | | 02/18/04 (Wed) | 02/22/04 |
| | | 02/27/04 (Fri) | 03/01/04 (Mon) | 02/27/04 & 03/07/04 |
| | | | | |
| 04/04 | 03/19/04 (Fri) | | 03/22/04 (Mon) | 03/21/04 & 03/26/04 |
| | | 03/31/04 (Wed) | 04/01/04 (Thur) | 04/04/04 |
| | | | | |
| 05/04 | 04/19/04 (Mon) | | 04/20/04 (Tue) | 04/25/04 |
| | | 04/30/04 (Fri) | 05/03/04 (Mon) | 04/30/04 & 05/09/04 |
| | | | | |
| 06/04 | 05/19/04 (Wed) | | 05/20/04 (Thur) | 05/23/04 |
| | | 05/28/04 (Fri) | 06/01/04 (Tue) | 05/28/04 & 06/06/04 |
| | | | | |
| 07/04 | 06/18/04 (Fri) | | 06/21/04 (Mon) | 06/20/04 & 06/25/04 |
| | | 06/30/04 (Wed) | 07/01/04 (Thur) | 07/04/04 |
| | | | | |
| 08/04 | 07/19/04 (Mon) | | 07/20/04 (Tue) | 07/25/04 |
| | | 07/30/04 (Fri) | 08/02/04 (Mon) | 07/30/04 & 08/08/04 |
| | | | | |
| 09/04 | 08/19/04 (Thur) | | 08/20/04 (Fri) | 08/22/04 |
| | | 08/31/04 (Tue) | 09/01/04 (Wed) | 09/05/04 |
| | | | | |
| 10/04 | 09/17/04 (Fri) | | 09/20/04 (Mon) | 09/19/04 & 09/24/04 |
| | | 09/30/04 (Thur) | 10/01/04 (Fri) | 10/03/04 |
| | | | | |
| 11/04 | 10/19/04 (Tue) | | 10/20/04 (Wed) | 10/24/04 |
| | | 10/29/04 (Fri) | 11/01/04 (Mon) | 10/29/04 & 11/07/04 |
| | | | | |
| 12/04 | 11/18/04 (Thur) | | 11/19/04 (Fri) | 11/21/04 |
| | | 11/30/04 (Tue) | 12/01/04 (Wed) | 12/05/04 |
| | | | | |
| 01/05 | 12/17/04 (Fri) | | 12/20/04 (Mon) | 12/19/04 & 12/26/04 |
| | | 12/30/04 (Thur) | 01/03/05 (Mon) | 12/31/04 & 01/09/05 |

- *Payment may be received on dates other than those listed.*
- *Report dates reflect the actual cycle date; receipt will depend on transfer medium.*
- Dates are subject to change due to holiday schedules.
- When the recoupment cycle runs on a Monday, actual recoupments will appear on the following week's R&S statement.

**ADDENDUM X**

**PERFORMANCE IMPROVEMENT PROJECTS**

**FORMAT A**
**EXECUTIVE SUMMARY OUTLINE***

Date _____

Organization _____

Person(s) Completing Executive Summary _____

Title(s) _____ Telephone _____

**A. Health or Psychosocial Service Delivery Area of Concern**

1. Study Topic. (Briefly define problem; explain its impact on participants' health.)

2. Methods used to identify need for QI study.

3. Are there guidelines, standards, QI indicators, and/or protocol related to the study topic?

4. If yes, attach copy.

**B. Identification of Population and Sample**

1. Describe the population at-risk, in terms of size of population and age, sex, race/ ethnicity, risk factors/conditions, as appropriate.

2. Describe the risk level of participants.

3. Time frame of the study.

4. Describe how the sample was selected.

5. Sample size.

**C. Data Collection**

1. Describe data sources. (Include dimensions of the problem as perceived by staff, relatives, participants, when appropriate.)

2. Describe collection methods that may include consultations, interviews, chart reviews and/or physical exams.
3. Describe data retrieval process and attach a copy of the data collection tool.

**D. Data Analysis and Interpretation**

1. Describe or attach copy of the study findings.

2. Describe or attach a treatment plan summary for individuals according to their normal or high levels of risk in order to prevent and/or reduce risk.

3. Describe or attach copy of the follow-up plan and any continuous quality improvement strategies. (*Include action plan to avoid problem's recurrence.)*

4. Will this topic be restudied or continuously monitored?

5. If yes, describe plans for the next study and for any changes in the study design.

* Attach each QI study using this ADDENDUM X, FORMAT A, as the cover page.

**PERFORMANCE IMPROVEMENT PROJECTS**

**SPECIAL MANAGED CARE PROGRAMS**

# PERFORMANCE IMPROVEMENT PROJECT REPORT*

## Format B

Answer the following ten (10) questions in narrative format. Attach tables, graphs, specifications and appendices as appropriate.

1. In a single sentence, state the question your study answers. Ideally, it should be stated in such a way that the data you collect and analyze provides an unequivocal answer.

2. Explain why you selected this topic.

   - Consider whether you are studying a condition that is prevalent in your patients. If it is not Wisconsin has a web based system for determining functional eligibility. The site completes the screening tool and eligibility is determined via a algorythem within the application. The State has a system of remote quality assurance checks on the information entered on the screen. prevalent, is it important for some other reasons? These reasons might include a condition of low prevalence but of very serious consequences; or a condition that you have some reason to believe (from internal anecdotes or external literature) can be better managed.

   - If you are studying some infrastructure feature (how referrals are processed, adequacy of transportation, etc.) rather than a particular condition, please relate this feature to the status of your patients.

   Because resources available to do studies are limited, explain why you chose this topic rather than other possible worthy topics.

3. Describe the data you collected to answer the question. Include any data specifications you used. How was the data defined? In what ways was the data limited? If not everybody who could be studied was studied, how did you decide who was in the study and who was out? If eligibility criteria were used, why did you set the particular eligibility standard? How many potential patients were lost to the study because of this eligibility standard or other exclusion criteria?

4. Describe the data collection method. What was the source of the data? If data collection required expert judgment, explain how you know the expert judgment was accurate. Consider issues such as the general professional training of the data collector, and specific training provided for data collection. If more than one person collected data and data collection required expert judgment, how do you know the data collectors made the same judgments?

5. Did you use some standard or norm to set expectations in your study? If yes, what standards were used? Were they from an external source such as a professional guideline or were they

internal standards such as last year's performance. Explain why the standard you selected applies to your program, your study, or your patients?

6. What were your results? How did you relate your findings to any standard (if used) and to your study question? What "numbers" resulted from your study? If your study did not produce quantifiable measurements, please explain. Did your results lend themselves to the statistical analysis? If yes, please explain the tests used and the meaning of their results. In a single statement, what answer does the data collected and analyzed make to the study question? Are there any other ways to interpret the data? Please explain.

7. What were the limitations of your study? These may include any difficulties encountered as part of data collection or competing ways to interpret the findings. Consider if the conclusion applies to other programs, all your patients within your program, all your patients with a particular condition or need, only those patients you studied, or patients in other programs.

8. What would you do differently to study the same question next time? Do the findings from your study suggest that the study question might be better answered using a different approach? If so, what approach?

9. What are the next steps, if any, to study this question/topic? What additional questions did your study raise?

10. What will you do differently as a result of your study? What findings from this study will be useful to you in changing your organization's management of patient care? What changes will occur as a result of this study that will significantly improve the quality of services you offer?

- Attach each QI study using this ADDENDUM X, FORMAT B, as the cover page.

## ADDENDUM XI

## AIDS/VENTILATOR DEPENDENT REPORT FORMAT

**A. Report Formats.** CCP shall submit the following report in hard copy format and in Microsoft® Excel or tab delimited text format on an ad hoc quarterly basis:

**Community Care Partnership, Inc.**
**AIDS/Ventilator Dependent Report – Excluding Long Term Care Service Costs**
**[Report Date]**

[Member Name] [Medicaid ID #]

| Provider Name | Provider Medicaid ID # | Diagnosis Code | Procedure/ Drug Code | Procedure/ Drug Description | From DOS | To DOS | Units | Total Amount Billed | Amount Paid for Medicare-Covered Service | Amount Paid for Medicaid-Covered Service |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | |
| | | | | | | | | | | |
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| | | | | | | | | | | |
| | | | | | | Total | | | | |

**B. Report Field Descriptions.**

| Field Name | Description |
|---|---|
| Report Date | Date report was completed. |
| Member Name | First, MI, and Last name of member. |
| Medicaid ID # | Member's Medicaid identification number. |
| Provider Name | Name of provider |
| Provider Medicaid ID # | Provider's Medicaid identification number. |
| Diagnosis Code | ICD-9 code. |
| Procedure/Drug Code | CPT or national drug Code. |
| Procedure/Drug Description | Description of procedure or drug. |
| From DOS | From date of service, expressed as yyyymmdd. |
| To DOS | To date of service, expressed as yyyymmdd. |
| Units | Quantity of units of service. |
| Total Amount Billed | Total amount billed by provider for Medicaid and Medicare services. |
| Amount Paid for Medicare-Covered Service | Amount CCP paid to provider for Medicare-covered portion of the procedure/drug. |
| Amount Paid for Medicaid-Covered Service | Amount CCP paid to provider for Medicaid-covered portion of the procedure/drug. |